



its relative infancy and it will be necessary for it to create an effective research base for its patient population.

## Training in forensic psychiatry in Israel

Child psychiatry is the only designated sub-speciality in psychiatry recognised by the Israel Medical Association. In 1995 the Israel Forensic Psychiatric Association submitted a proposal for forensic psychiatry to be recognised as a sub-speciality (Silfen & Levy, 1995). However, in the absence at that time of any established training schemes in forensic psychiatry and any comprehensive secure facilities within the health sector, the proposal was not accepted. A postgraduate training scheme in forensic psychiatry was then established in 1997 at Tel Aviv University, the course being of 2 years' duration on a day-release basis, and has included up to two visiting lecturers from Britain. About 40 Israeli psychiatrists have now completed the Israel Diploma in Forensic Psychiatry and interest in the field is growing. There are as yet, however, no professorial chairs in forensic psychiatry in Israel, the advancement of the proposed sub-speciality having been driven by general psychiatrists with a special interest, including two who are professors of clinical criminology.

## Future developments

Forensic psychiatry is developing in Israel with an established postgraduate programme and the evolution of a new secure facility for MDOs within the health sector. There is a need to develop a more comprehensive research base, which may be facilitated by the eventual recognition of forensic psychiatry as a designated sub-speciality. Links in forensic psychiatry between Britain and Israel have been developing, with conferences having now been held on four occasions in both countries. Palestinian psychiatrists have attended three of these. If peace was to reign on its borders, mutual links in forensic psychiatry would also probably develop further between professionals in Israel and its Arab neighbours.

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## Almost an electronic patient record and almost free

### The CLINically Useful Enquiry System (CLUES)

#### AIMS & METHOD

This paper describes a project to make all the patient letters held on secretaries' computers available 24-hours a day to improve patient care and risk management. Following a system audit a solution using existing resources was constructed.

#### RESULTS

The implementation of a uniform coherent patient letter naming and filing convention (the CLINically Useful Enquiry System) allowing rapid access to letters to support effective care without massive cost or disruption.

#### CLINICAL IMPLICATIONS

This process can be quickly, simply and cheaply replicated in any organisation with a network supporting e-mail and has the additional benefit of making transition to a future paperless system fast and economical.

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In the future you will have a computer system that electronically links clinical information and data for central returns and local requirements available 24-hours a day, obviating the need for paper records at all. Today the routine is to stumble along with paper records and letters typed up on word processors. Often medical files are not to hand when you need them and it is necessary to resort to the Darwinian random access memory (RAM). When on-call it is routine to manage out of hours without medical records. Patients at high risk consume large amounts of clinical time owing to unreliable researching of their background. The quality of decision making suffers as a result.

The original concept was to make available all the clinical letters stored on the secretaries' computers. The collaboration between the clinician author (G.S.) and the information technology authors (T.R., A.S., D.P. and G.O.) revealed a number of unexpected benefits (see Box 1) available at low cost without changing clinicians' work patterns.

## System audit

In an initial feasibility study we surveyed the working practices of all the medical secretaries, checked that their word processor packages were compatible and checking their connection to the network. A real-life test of the capacity of the network links was done to see if it was feasible to work with the files on the central network computer (as this would have been part of the ideal solution). Printing a document took 2–3 minutes of computer 'thinking time', with only a single secretary using the link. Because the link would slow further if more secretaries were using it we abandoned that option.

## Solution construction

### Holding the patient files

The slow links led us to a solution in which the secretaries saved their work on the small network computer on each dispersed site, to which there were fast links. The routine

#### **Box 1** Benefits of the CLinically Useful Enquiry System (CLUES)

- Improved service for patients, more effective treatment
- Improved risk assessment of patients with more accurate and timely information
- Less time looking for records, increasing effective working hours
- Speed and simplified sending of clinical information to other organisations
- Ease of eventual clinical information transfer to a paperless system
- Ensured uniform letter structure to facilitate the Care Programme Approach
- Improved security and backing up of files
- Improved staff computer skills and awareness

backing up of these computers gives protection from loss of files by accident, theft or hardware failure. To allow clinicians to find a patient's folder, which could be at any of 10 separate sites, a small program was written to send the names of all the patient folders to a central register that could then be easily searched, directing the enquirer to the correct site.

## The naming convention

Secretaries use their own personal system of saving their work where they can find it. I have three secretaries who type letters for me; each had a different filing system. Searching was only straightforward with the secretary who had created the system. None the less, these saved documents were often critical to patient care, as it was possible to quickly create an outline of the patient's care without the physical notes.

Our filing solution is to give each patient a folder with his or her name (surname, first name) and date of birth, for example, Siddal, Mary, 27-03-76. Within this folder are the individual documents identified by type and date, for example, initial assessment, 02-11-99. The document types/names used are defined in the training manual and no flexibility is allowed. When patients move between teams their electronic record can also be transferred by e-mail, and name changes can easily be accommodated. This system minimises training need and is simple and flexible.

Looking forward a few years to paperless notes, one can predict that without the clinically useful enquiry system (CLUES) structure, filling a new computer with clinical data to make it useable from the outset will be very expensive as each file must be opened and identified before being transferred to the new system. Starting with an empty system is more expensive as costly clinicians' would have to fill it while still relying on old notes (and where do they find the time?). None the less, migration of files to CLUES is the single largest cost of the change.

## Templates

Another benefit of CLUES is that the secretaries create each document from a template to which they can add but not delete. Besides creating a uniform corporate image, this eases the implementation of new documentation as part of the Care Programme Approach as the templates are updated centrally and then distributed electronically. In addition a single variety of notepaper for the trust can be ordered if site and unit details are included in the template.

## Searching the files

Windows (and other PC operating systems) has a search program built in that can find folders, files or text, even if you have an incomplete name. A user can select the CLUES folder either in his/her own site computer or elsewhere and search for a name. In our decentralised system we created patient folder lists for each site and



hold them centrally in order to facilitate this search. With a centralised system one would be able to simply go to the CLUES folder and search alphabetically by surname.

## Training

Specific training has been devised that takes about half an hour or so (more for senior clinicians). This follows a modular scheme because users' needs vary. All are given education concerning networks, which is another spin-off benefit. A one-sided summary 'cheat sheet' was given to everyone who was trained.

## Security

All the computers have passwords. To use e-mail on a network the individual user has to log-on and provide a further user name and a password. This system can also allow selected sites or folders to be accessed throughout the network. This is the main security used by CLUES. We decided on three levels of file access (see Box 2). There are some clinical cases that are more sensitive than others (e.g. members of staff), and thus there are two clinical records files at each site, with access to the confidential records limited to senior members of staff and their secretaries only. Discretion prevents detailed description of all the security features from being discussed here.

One of the most contentious issues was whether to label patient folders with names or numbers. Numbers are clearly more secure as one must have access to a master index to find a patient's record. But the ease of daily use facilitated by a surname-based structure led us to adopt the system described above.

There is the risk of unauthorised access at unattended work stations, or from secretaries giving their passwords to locums, but this is specifically covered in the training given to all staff. One unexpected benefit is that by having the patient information in a computer hidden in an unmarked cupboard it is physically more secure and the easily stolen desktop computers no longer contain patients' clinical details.

### Box 2 Security groups, levels of file access

Level	Group	Description
1	Consultants and their secretaries, senior on-call clinicians	Full access to all folders at all centres
2	Other permanent staff	Full access to routine folders. They do not have access to the folders for confidential records
3	Short-term temporary staff	Access to routine folders on local site only

**Table 1. Implementation costs for 19 consultant teams**

Item	Cost (£)
Computer upgrades	1500
Staff training time	3500
Trainers	800
IT time	210
Migration (temporary secretarial)	15 000
Total	21 010

For 10 sites, 19 consultant teams; each with three secretaries and 10 clinical support staff.

## Costs

Migration cost is the greatest and the least accurate because we did not survey how many files needed renaming or the time per file. One can avoid this by putting only new documents on the system, but this means that clinicians would not find the system useful for perhaps a year or so. Hardware/infrastructure costs were for two PCs capable of running the necessary word processor package. Spare storage on the site network computers allowed us not to upgrade these. Training not only costs the trainer's wage but also the work time lost. All of these are one off's (see Table 1).

There was also a small annual cost from the upgrading of one of the secretaries to work extra hours and have seniority to administer, liaise and train new users of CLUES. There is also a CLUES manager, but this costs nothing as it has been added on to other duties.

## Discussion

The starting point for CLUES was a simple one: 'We want the letters the secretaries type to be available 24-hours a day'. The solution sprang from the authors' inventive minds. This system is rare as its creation was clinician driven and not produced to satisfy central information requirements. This is not a commercial system because it is too simple, too obvious and there is no software or hardware to buy. None the less, local clinicians have welcomed it enthusiastically and when the time comes to migrate information to an integrated solution we expect our managers will be even happier. That it is almost free is because it uses facilities that already exist in the software, but that are not used. As trailing edge technology, it is very unlikely to be troublesome once in use. Anyone wishing to set up a similar system can take elements rather than the whole package and then use their existing systems inventively. The key is the naming/filing convention, without which nothing else works. Although CLUES took about 600 person hours to develop, any copy will need a tenth of that time, but critically one must have clinicians, managers and the IT department committed to it and working together before starting.

Anyone wishing to develop their own similar system can obtain a CD-ROM copy of the full documentation of the project from the corresponding author at nominal cost or from the website <http://www.dorsethealthcare.org>.



The authors cannot enter into correspondence concerning the implementation of similar systems.

(medical records) and Nigel Rogers and Roy Clements (IT).

## Acknowledgements

Thanks to the CLUES team: Joe Jackson (head nurse), David Ozanne and Jane Elson (managers), Bernie Gray

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Psychiatric Bulletin (2002), 26, 148–151

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# Service innovations: attention-deficit hyperactivity disorder – development of a multi-professional integrated care pathway

## AIMS AND METHOD

There is a need for multi-disciplinary input into the diagnosis and management of attention-deficit hyperactivity disorder (ADHD). We describe the development of a multi-professional integrated care pathway incorporating education, community paediatrics, child and adolescent mental health services and general practice.

## RESULTS

Using parent-held documentation this pathway forms the basis of a community-based ADHD clinic.

## CLINICAL IMPLICATIONS

A training programme for schools and health professionals raises awareness of the features of ADHD and covers appropriate management within schools.

Attention-deficit hyperactivity disorder (ADHD) is a neurobehavioural disorder affecting 0.5–1% of British school children (Taylor & Hemsley 1995). The affected child often has difficulty learning, giving rise to special educational needs that, combined with poor peer and family relationships, can lead to lack of self-esteem (American Psychiatric Association, 1994). ADHD is commonly associated with other developmental disorders, such as speech and language delay or specific learning difficulties, and with conduct disorder or oppositional defiant disorder (American Psychiatric Association, 1994).

When a diagnosis of ADHD is considered, assessment should include an interview with the parents as well as direct consultation with the school (American Academy of Pediatrics, 2000). The diagnosis should only be made when the child meets the DSM-IV (American Psychiatric Association, 1994) criteria, and the evaluation should include assessment for comorbid conditions.

Not all children with ADHD will need stimulant medication and a number may be managed solely with behavioural interventions (Hill, 1998). Direct comparison of stimulant medication with behavioural interventions suggests that the former is relatively more effective (Miller *et al*, 1998), however the combination of behavioural management plus medication offers greater power than behavioural management alone (MTA Cooperative Group, 1999). The addition of medication to behavioural treatments is clinically effective and relatively

cost effective (Lord & Paisley, 2000). Thus, if the response to behavioural methods is insufficient, a trial of medication should be considered. Treatment should be initiated by child and adolescent psychiatrists or paediatricians with expertise in ADHD, although continued prescribing may be performed by general practitioners (GPs) under shared-care guidelines. Children receiving medication should receive regular monitoring (National Institute for Clinical Excellence, 2000).

Much has been made of the need for more integrated working between the different professional groups involved in the care of children, particularly in the arena of child mental health (Graham, 2000). ADHD, with its effect on all aspects of a child's life, but particularly on education and learning, lends itself well to this approach. There is a need for cooperation among the different professional disciplines, and for more joint working between child and adolescent mental health services (CAMHS) and paediatric services. Community paediatricians, with their close working relationships with schools and expertise in developmental paediatrics, are ideally placed for this role.

## Background

In mid-Cheshire a multi-professional team for ADHD was established in August 1999, jointly funded by the Cheshire Community Healthcare Trust and the Cheshire