Letters

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Identifying patients at risk of psychosis

It was pleasing to see this study by Strelchuk *et al* in the *BJGP*[1] as more areas in the UK develop At Risk Mental State (ARMS) services as they aim to meet the requirements of the Long-Term Plan. GPs are crucial in the mental health pathway, but I worry that the burden of expectation is too high. Secondary care services are insufficiently aware of the concept of ARMS and the challenge in galvanising clinical and commissioning support is considerable. Traditionally, Early Intervention Services have embraced diagnostic uncertainty, but burgeoning caseloads would seem to have impacted on this in favour of self-preservation. Maybe the model for ARMS needs to be directed at community areas with a higher incidence of psychosis and to use support workers with lived experience who can follow the patient journey and advocate where necessary. This may be one of the ways of addressing the inequalities in treatment access and outcomes for Black, Asian, and minority ethnic communities where treatment is unfortunately more likely to be coercive.

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Realising the potential of Improving Access to Psychological Therapies for older adults

I read with interest the barriers to uptake of Improving Access to Psychological Therapies (IAPT), particularly those pertaining to the misconception that depression is part of normal ageing.[1] The misattribution of symptoms as part of the ageing process is what I have since seen described as the 'understandability phenomena', which may prevent older people from seeking help when depressed.[2] The manifestation of physical rather than emotional symptoms seen in older adults with depression[2] means that GPs need to be vigilant towards atypical presentations and be mindful that it can be difficult to detect depression in this population.

The editorial suggested social isolation as a risk factor for depression, a circumstance no doubt perpetuated by the COVID-19 pandemic. To aid in the recognition of deteriorating mental health in older patients, we should be able to recognise life events and social situations that can potentially have an impact. To elaborate further, the following factors could contribute to a decline in mental health in older adults: bereavement;[3] living in care settings;[4] dependence on others;[3] and the patient as a carer.[5]

I wonder if uptake of IAPT could be improved with an increased knowledge of the situations in which it is appropriate to refer? NHS England suggests that in primary care we can refer to IAPT not only for depression/anxiety, but also for: bereavement difficulties; family/relationship/interpersonal difficulties; difficulty adjusting to health problems; and medically unexplained symptoms.[3]

I would like to direct my colleagues to the Royal College of General Practitioners Mental Health Toolkit, which has a plethora of useful information in the section regarding mental health in older adults. I would also encourage interested individuals to look at the strategies that local clinical commissioning groups have undertaken to increase uptake of IAPT. Good practice seen nationally includes the appointment of Older People's Mental Health Champions and the implementation of integrated physical and mental health care.[6]

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It wasn't always rosy ...

I enjoyed reading the article by David Zigmond and agree with him regarding how general practice has changed for the worse.[1]

However, it wasn't always rosy before the reforms. My senior partners told of stories in the early 60s of awful morale and conditions in practice before the deal they got — largely exploitation by senior doctors who made their junior assistants' lives miserable. The new contract enabled group practice and development of practice teams,

I think that with hindsight the reforms of 2004 were a mistake for the profession. Primary healthcare teams as I knew them were destroyed. This and other changes led to the present lack of morale in the profession, and the altered perception of the profession