

## LETTERS

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### Mental health promotion for young adolescents in primary care: a feasibility study

Sir,  
Adolescence is a time of emotional turmoil for many young people.<sup>1</sup> Psychiatric morbidity in this age group can be remarkable persistent and handicapping,<sup>2</sup> and affect physical health. We examined the feasibility of using a health promotion clinic in primary care to explore physical and mental health concerns, and to identify adolescents at high risk for depressive disorder. The attendance rate to our clinic was 22% (25/115 registered 14–15-year-olds approached). This is lower than in the health check clinics reported by Donovan & McCarthy<sup>3</sup> and Townsend *et al.*<sup>4</sup> Our lower rate could well be caused by the ethnically diverse and socially deprived inner London nature of our sample. Uptake for other health promotion clinics was also low within the practice. Interestingly, attendance was significantly higher when adolescents were invited to come on their own than when their parents were invited too [7/17 or 41% versus 18/98 or 18%;  $P = 0.04$  on the Fisher test; odds ratio (CI) 3.1 (0.9 – 10.5)]. We noted that confidentiality was an important con-

cern amongst those who attended.

Psychiatric interviews revealed that half (11/25) the attenders of our health promotion clinic had a psychiatric disorder. Psychiatric morbidity was not trivial: it was associated with problems in relationships and in adjustment to school as well as with physical symptoms (see Table 1). The most common diagnosis was depressive disorder (six subjects). We estimated that our clinic may have attracted all registered youngsters with depressive disorder (6/115) since this gives a rate of 5.2%, which is comparable to expected rates in adolescence.<sup>5</sup> However, most psychiatrically disordered youngsters had attended their general practitioners in the previous year (see Table 1), and we conclude that it would be more cost-effective to facilitate the recognition of psychiatric disorder and distress during routine surgery attendances for a population such as this.

We offered a psychotherapeutic intervention at the surgery incorporating cognitive psychotherapeutic elements to eight youngsters with depressive or mixed emotional disorders: four attended and three felt subjectively improved. The comparatively low uptake has to be set against the fact that, although mixed somatic/psychological presentations were commonly identified by the medical practitioners

during these youngsters' routine visits to the surgery (see Table 1), none had been referred to secondary mental health clinics. This would indicate that primary care has a role to play in attending to psychological distress for many youngsters who may not otherwise have access to sources of help.

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#### References

- Rutter M, Graham P, Chadwick O, Yule W. Adolescent turmoil: fact or fiction. *J Child Psychol Psychiatry* 1976; **17**: 35-36.
- Cohen P, Cohen J, Brook J. An epidemiological study in late childhood and adolescence — 11. Persistence of disorders. *J Child Psychol Psychiatry* 1993; **34**: 869-878.
- Donovan CF, McCarthy S. Is there a place for adolescent screening in general practice? *Health Trends* 1988; **20**: 64.
- Townsend J, Wilkes H, Haines A, Jarvis M. Adolescent smokers seen in general practice: health, lifestyle, physical measurements and response to anti-smoking advice. *BMJ* 1991; **303**: 947-950.
- Harrington R. Affective disorders. In: Rutter M, Taylor E, Hersov L (eds). *Child and adolescent psychiatry, modern approaches*. Oxford: Blackwell Science, 1994.

**Table 1.** Characteristics of disturbed and non-disturbed attenders at the Health Promotion Clinic.

	Disturbed (n = 11)	Non-disturbed (n = 14)	Fisher test P-value
<b>Demographic features</b>			
Boys/girls	6/5	8/6	NS*
<b>Symptoms</b>			
Problems with:			
peer relationships	6	1	0.01
school	10	3	0.007
parents	9	1	0.0002
Frequent psychosomatic symptoms	4	1	0.09
<b>GP contact</b>			
In previous 12 months	10	10	NS
Reason for presentation:			
somatic	4	7	NS
mixed somatic/psychological	6	3	

\*NS, not significant.

### General practitioners and public health doctors: sharing common goals?

Sir,  
I welcome the editorial by Graffy & Jacobson (December *Journal*, p.640). The merits of collaboration between public health medicine and general practice have been well aired. A practical discussion of the ways in which both disciplines can work together is long overdue. The first proposal, of shared involvement in needs assessment, is essential, but I am concerned that the authors seem to be suggesting, intentionally or otherwise, that general practitioners should support the