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.[1] Psychiatric morbidity in this age group can be remarkable persistent and handicapping,[2] 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[3] and Townsend *et al.*[4] 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 concern 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.[5] 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.

ALISON WESTMAN
M ELENA GARRALDA

St Mary's Hospital Medical School
Imperial College of Science,
Technology and Medicine
University of London
Norfolk Place
London W2 1PG

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
Demographic features			
Boys/girls	6/5	8/6	NS*
Symptoms			
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
GP contact			
In previous 12 months	10	10	NS
Reason for presentation:			
somatic	4	7	NS
mixed somatic/psychological	6	3	

*NS, not significant.

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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

work of public health. This contrasts with the current policy of primary-care-led purchasing, which is founded on health commissions supporting primary care.

The authors final contention that good links at a local level will be important lacks detail. I would suggest that a practical way to establish these links and address the issue of public health medicine as the most appropriate professional discipline in health commissions, supporting primary care purchasing, is for public health consultants to work on a sessional basis with a group of general practices. Because of public health manpower and the requirement for a reasonable population base to undertake epidemiological needs assessment, these groups could not be less than 40 general practitioners serving a population of not less than 75 000. The sessional commitment to the practices should be protected, and practice-based office space and administrative support provided to the public health physician.

Apart from policy, there are many other good reasons for adopting this approach. First, public health delivered entirely from a central organization, even with the support of general practice, still detaches much of the decision-making from the place where patient care is delivered. Secondly, the general practitioners who undertake sessions in a public health department are likely to be differently motivated from the majority of their peers. Thirdly, because of different work schedules and priorities, problems inevitably arise trying to bring general practitioners and public health physicians together in public health departments. Lastly, the added value of public health, (e.g. by advising and evaluating preventive programmes, and supporting audit and primary care management) may be reduced by separating public health from the general practice setting. The two disciplines should not only work together, but do so where it really matters, in the community.

QUENTIN D SANDIFER

Directorate of Public Health Medicine
South Glamorgan Health Authority
Temple of Peace and Health, Cathays Park
Cardiff CF1 3NW

Reaccreditation of general practitioners

Sir,

Papers on this subject, such as those published recently,[1,2] although usefully fostering debate, still tend to make light of the difficulties associated with reaccreditation. All tests produce false-positives and false-negatives. This system will purport to reaccredit only those worthy of the public's confidence, and only fail those deemed no longer fit to carry the responsibilities of active practice. It will be necessary to prove to all concerned that whatever tests are devised are capable to distinguishing the worthy from the unworthy with a degree of reliability that is beyond our experience. This places a considerable obligation upon all who advocate any system of reaccreditation that could end medical careers prematurely.

Furthermore, the costs of reaccreditation may be very high indeed, and effects upon professional morale are probably unquantifiable. Whilst I accept that doing nothing also carries costs, yet another journey into the unknown is unlikely to help general practitioners who are still suffering the effects of the imposed New Contract. Perhaps this is why the 1995 Conference of LMCs was so cool about it?

In future, colleagues may face the threat of failing to be reaccredited. I believe that I, like many others, am sufficiently well versed in the language of audit, quality and education to be able to coach borderline candidates to safety. Whether this would improve their professional practice, let alone the care their patients receive, is dubious. Whilst such a possibility exists, any proposals for systems of reaccreditation must be treated with proper scientific scepticism.

JOHN HOLDEN

The Medical Centre
Station Road
Haydock
St Helens WA11 0JN

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Prescribing performance

Sir,

Bateman *et al* (January *Journal,* p.20) aim to develop a range of criteria of prescribing quality so that standards can be set '...which must be widely applicable and have credibility among the general practice profession.' This is a laudable aim, but one which is very difficult to achieve. For example, look at some of the markers of good prescribing adopted by their consensus group. A practice gains one point if over 90% of antibacterials prescribed are from a list of 12, yet that list excludes clarithromycin, which is strongly recommended by Phull & Jacyna for *Helicobacter* eradication in the same edition (letter, January *Journal,* p.48). Some of us who prescribe for drug abusers according to local guidelines would not met the criterion for good prescribing as far as benzodiazepines are concerned and not all would agree that good prescribing means withholding selective serotonin reuptake inhibitors from over 75% of depressed patients.

I have no doubt that the consensus group enjoyed defining standards which are appropriate for its members and learnt a great deal as a result. If it was left at that, there could be no complaint and the authors do acknowledge in the discussion section of the paper that the numeric standards might require adaptation for different local or regional population needs. But by seeming to maintain in the summary that their standards are widely applicable, they risk creating a weapon which could be used by managers who do not know or even care that they may be inappropriate for others. If practices are rewarded in some way for meeting specific criteria, there will be a temptation to achieve these goals even if the result is a poorer standard of car.

Ventures such as this risk inhibiting therapeutic progress. Changes in prescribing patterns over the years usually come about gradually. An individual prescriber changes to a new form of treatment, perhaps after recommendation from a colleague or reading an article in the medical press. If the new treatment is successful, it is prescribed again, and if this success is reproduced, the new treatment is established and recommended to other colleagues. Other initiatives are not so successful and do not become accepted practice. By establishing set standards, this process is inhibited because a change in prescribing habit could result in failure to meet a target. In the example I have already quoted, prescribers would be reluctant to use clarithromycin for *Helicobacter* eradication if these standards were in force, and so its adoption for this purpose, even if it were more effective, would be delayed.

We should think very carefully before promoting specific prescribing standards for other than those who played a part in developing them and who have the power to review them as short notice.

IAN MCKEE

Westerhailes Health Centre
7 Murrayburn Gate
Edinburgh EH14 2SS