Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

Working with drugs users

Sir,

Deehan *et al* ascertained views from general practitioners about working with drug users and concluded that while policy dictates GPs become more involved in the care of drug users, they are unwilling and reluctant to do so even when provided with training and support (November *Journal*)[1]. We read with interest the results of this study and agree with the authors that if the government's policy for managing drug users through shared care schemes is to work, GPs must be encouraged to work with drug users. However, far from being an unwilling group, as the authors suggest, many GPs are looking after these patients and have actively sought to provide themselves with the support they need by developing a national network organization for GPs involved in the care of drug users in the primary care setting.

The network, provisionally entitled 'Primary Care Practitioners in Substance Misuse' (PRISM), is currently being developed and is expected to be launched in April 1998. It aims to improve the provision and effectiveness of care for drug users by promoting, encouraging and supporting practice and research in managing drug users in primary care. In addition, it will build on the principles of shared care, enabling experience gained from existing schemes to be used to inform new schemes in other localities where GPs are working unsupported. PRISM will disseminate information on good practice and research, provide opportunities for GPs to network with each other, organize advice and information on conducting research in a general practice setting, develop a library of information about the care of drug users in general practice, establish links with local and national bodies, and provide advocacy for GPs at relevant forums.

The need for such a network was identified at the first national conference for GPs working with drug users, in 1996. Delegates agreed that, while there has been a small increase in the support provided by specialist services, there is an urgent need to provide a national framework of GP support with secure funding.[2] At the second conference, in 1997, the need for research into effective care in the general practice setting was highlighted. PRISM has been developed to meet these needs.

It is essential that GPs are encouraged to work with drug users. A national organization of peer support networks of GPs will contribute to this process.

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Practice nurses and treatment of depression

Sir,

Mann *et al* (January *Journal*)[1] are to be congratulated on their paper, which shows how the best laid plans to improve services can go so wrong.

The considerable extra costs incurred by the increased prescribing of antidepressants in the nurse intervention group, which made no difference to the rates of recovery when compared with the control group, and the wide variation in the results achieved by some of the nurses in the nurse intervention arm of the study could have been avoided if the available research evidence had been used to inform the study design. Treating mild to moderate major depression with antidepressants has been shown in a number of studies to be less effective than CBT and interpersonal therapy.

As part of the result thus gained relies on the therapist, not the therapy, through the establishment of a strong alliance, I wonder if the authors could tell us if some of the nurses also showed this effect, which could have been due to their being more accomplished in developing a therapeutic alliance with patients than other medical professionals. If so, this would suggest that some of the nurses achieved a psychotherapeutic effect that was independent of the antidepressants prescribed and unaffected by the educational programme used — an effect beginning to be noted by GP counsellors, up to 15% of whose patients have symptoms of major depression.

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Reference

1. Mann AH, Blizard R, Murray J, *et al.* An evaluation of practice nurses working with general practitioners to treat people with depression. *Br J Gen Pract* 1998; **48:** 875-879.

Practice nurses and treatment of depression

Sir,

We note with interest that Mann *et al* found that having nurses working with GPs in assessing and providing follow-up

care for depressed patients was associated with 'excellent outcomes for both intervention and control groups.'[1]

Our practice, of 6100 patients, has been developing the role of the practice nurse in this area of care. The training consisted of study days covering depression and counselling, with mentorship from the GPs and attached community psychiatric nurse (CPN). Over a 28-month period from September 95 to December 97, a total of 316 patients were seen 1179 times by the nurse, and the number of new referrals from our practice to the CMHT fell from 137 in 1995 to 97 in 1996 and 71 in 1997.

An audit of a typical four-month period showed that 121 patients were seen 164 times (40%) by the GPs and 206 times (60%) by the nurse. The mean number of visits to the GPs in Mann's study was between 3.29 and 3.83 compared with our figure of 1.3. We found that 87% of the patients were suffering depression; 56% were already on antidepressants and 14% started treatment following initial assessment; 76% were monitored entirely by the GP and nurse; 16% were advised to seek help from a voluntary agency; and 8% were referred to the CMHT.

The practice nurse role is complementary to that of the doctor and community mental health resources, acting as coordinator of care (identifying patient needs and facilitating access to relevant community services), gateway to the Community Mental Health Team (CMHT), and supervisor of treatment of depressed patients using the Beck Depression Inventory (BDI) in the assessment and monitoring of response to treatment.

Our experience supports the Mann study view that the training of practice nurses produces a practice 'shift in attitudes and management that is beneficial to the outcome of depression.' However, we have also found this style of management has reduced the burden on GPs by bringing a collaborative approach to managing this problem.

Further research is needed into developing appropriate team approaches to mental health problems in primary care. We believe a nurse acting as coordinator of this extended team provides a valuable extra dimension to the care that we can provide for this group of patients.

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The MRCGP International

Sir,

It was a joy to read Iona Heath's 'Viewpoint' in the new section of the *BJGP* (November *Journal*)[1]. The opportunity for the College to develop an international examination has been obvious for the better part of twenty years and its introduction would provide a major stimulus to the recognition of the discipline of primary medical care, not only in the Third World, but equally in Europe and Scandinavia.

If general medical practice cannot identify a common core of knowledge, skill and culture, then the claims of those who founded the College nearly fifty years ago were illusions of a grandeur reserved for the more specialist branches of medicine. Resistance to the recognition that generalist practice is a branch of medicine for which special training is needed has paradoxically been most evident within the Board of Examiners of the College, who have claimed that postgraduate medical education in general practice is inextricably bound to the system of delivery of medical care within the British National Health Service. It has always been a mystery why the College Examiners should have failed to recognize that there is a core discipline of general practice within a primary care system applicable in any country.

The international influence of the College has not received the recognition it deserves. The founders of the College had an international vision which led to the creation of the Colleges in Australia, New Zealand, South Africa, Kenya, Malta and Zimbabwe. (Canada had established its own College independently.) Currently the International Committee enjoys contacts with an ever-expanding list of countries, including Pakistan, from whom there is a constant stream of requests for advice and assistance in developing primary medical care services. It is now nearly twenty years since the Government of Kuwait requested help from the College in developing primary medical care, and this was to lead to the very successful educational programme under Professor Robin Fraser and to the Kuwait Diploma in Family Practice (RCGP/Kuwait), now recognized as having an equivalence to the MRCGP. Iona Heath's visit to Pakistan followed an earlier visit by one of us (DG) as a member of the College's International Committee, to whom the request was made for assistance.

The status of general practice family medicine in many countries (and therefore the resources allocated to it) would be enhanced by an internationally recognized diploma examination as Iona Heath has understood. We are delighted that, as one of the sceptics suspicious of the College's motives in trying to create an International Examination, she should have been converted, and we hope she uses her influence as Vice-Chairman of the College Council to convert her peers. The rewards for the College, and more importantly for patients worldwide, would be immense.

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Osteopathy and somatic dysfunction

Sir,

In his discussion paper (October *Journal*),[1] Nefyn Williams describes the concept of somatic dysfunction central to osteopathic practice and proposes it as a useful paradigm for non-specific back pain.

Professor Ernst[2] responds by claiming the concept originated in, and is part of, conventional medical thinking, but then seems to misunderstand it by interchanging the term 'somatic dysfunction' with 'functional'. This out-dated term, used when diagnoses wavered between psychosomatic effects and conversion neurosis, may indeed characterize some conventional medical thinking on back pain, but it is quite different from Nefyn Williams's exposition of osteopathic concepts, as a careful reading of the paper would have made clear.

Not only do we not expect the central tenet of a major complementary therapy to be inadequately understood by a university department of complementary medicine, but we also do not expect to find it denigrated as a 'shifty paradigm' without the reasoned discussion that it was hoped the establishment of a university chair in this field would promote.

When an area of science is not progressing, and there is a possibility that this is due to the inadequate range of conceptual models in current thinking, then the