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Mental health workers

Primary care mental health workers (PCMHW) can go beyond the supplementation of services for those with mild to moderate depression and anxiety, as described by Elizabeth England and Helen Lester.[1] In our inner-city locality we have had a wider impact on mental health services, by changing the quality of care for people with severe mental illness, contributing to the assessment work of mental health teams, providing an additional client-based service within these teams, and engaging in research and service development.

Case management of people with severe mental illness is poorly developed in general practice, and despite much exhortation over a decade or more there is little evidence of shared care of patients with schizophrenia, severe major depression and bipolar disorders. We have demonstrated that PCMHWs can act as case managers for patients with severe mental illness, collating clinically and socially relevant data and capturing it in electronic templates that are modifiable in routine consultations.[2] This process of data capture involves using structured checklists in interviews with patients, and similar structured data extraction tools for analysing community mental health team records as well as those in general practice.

Moving between primary and secondary care also allows the PCMHW to contribute to community mental health team work, particularly in assessments of new referrals, and by providing a client-centred service to those who do not meet the criteria for secondary care provision. Working under supervision of secondary care and being part of this supportive team helps with the professional development of PCMHWs. This training then becomes an asset in expanding the range of practice-based services for patients with mild to moderate anxiety and depression. Finally, research and development work includes promoting training in identifying and responding to depression in teenagers, using a modified form of cognitive behavioural therapy, during routine GP consultations.[3]

The description of the tensions in developing the role of the PCMHW given by England and Lester resonates with our experience, where the roles of the new workers have been jointly negotiated by practices, the mental health trust, the PCMHWs themselves and the primary care trust. These negotiations have been fruitful, but funding problems, particularly around supervision, remain an obstacle to continued development of PCMHW roles.

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Handshakes and spoof publications

The Letter 'The meaning of the handshake towards the end of the consultation'[1] from the April edition of the *BJGP* brought much amusement whether this is an 'April fool' or a piece of 'off the wall' research. I have to assume it is a joke for several reasons:

- If it was real, only 1.2% of his patients are pleased with his consultation style (ergo-98.8% may have some significant reservations about him and therefore he would be unwise to let his appraiser know.

- If it was real why didn't he get it published in the normal way ? Easy to answer that one; no sane ethics committee would let this one past. And how could you justify spending time getting consent from the participants for such nonsense?

- If it was real he should have looked more broadly at the topic. Why do others not shake hands? What difference does cultural background of patient or doctor make? What about class, socioeconomics or education?

Anyway, what difference does it make except that you would have to wash your hands again.

Anyway, nice one. You nearly had me fooled into thinking both the Editor or the doctor had been daft publishing this when I realised it was April.

A more important debate is whether any journal be permitted to publish spoof material in Medline searchable format. I have long been of the opinion that for internationally-read journals the practice should be banned and that any breach should be regarded as research fraud. You may feel this is an overreaction but unfortunately I have seen spoof articles referenced in serious papers. The distinction is not always clear even to those whose first language is English and I believe it is insulting and arrogant to deceive other professionals who have to waste time trying to work out what is real.

At least the *BJGP* have not fallen into the practice of publishing pretend original research (or have they?)

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Comment from the Editor

The *BJGP* would never knowingly publish a spoof, and we hope we have not been party to publishing pretend research. However, this letter appears to ask a 'have you stopped beating your wife?' question. Either we are guilty of relaxing our critical standards, or we have been taken in by a spoof. Not very comfortable, in either case.

David Jewell

Jury service

I was pleased to read that on the whole Paul Head found his jury service an enjoyable experience.[1] Personally, I dread being called and indeed as a practice my partners and I have taken out an insurance in case of such an eventuality. I was also given a useful bit of advice by a solicitor of my acquaintance: when called for jury service start to cultivate a little Hitler moustache and turn up on the day in a pin-striped suit with a copy of the *Telegraph* under your arm. The defendant will quickly reject you as a potential juror. Clearly, this will not work for my female colleagues but perhaps they could dress up as Mary Whitehouse?

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Embracing clinical supervision

Regarding John Launer's piece on embracing clinical supervision,[1] may I make the following suggestions? They are based on my experience of facilitating the development of a monthly 2-hour 'clinical peer review meeting' held within our practice on a Friday morning between 8 and 10am, and attended by all partners not on leave and some practice and district nurses. Many practices have been running such meetings for years, under various different guises.

- The agenda for such meetings should be wholly owned by the participants, and have no political drivers.
- The educational content should be developed by and mainly delivered by the participants.
- GPs should recognise the wealth of collective educational value they have within themselves. Once allowed to express it, even a small group of GPs has an abundance of hidden talents, skills and latent knowledge, and those deriving from areas beyond medicine should also be encouraged.
- A multiplicity of styles of delivery should be welcomed, and no norm expected.
- Departments of postgraduate GP education could help most by delivering funding for locum cover where possible.

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The article 'Moving on from Balint' by Dr John Launer, that appeared as an Editorial in the last issue of *BJGP*[1] is very timely and forward looking. I had the privilege of taking part in GP seminar's run by the Tavistock Clinic, for nearly 13 years. Through attending and taking active part in this professional development my quality of consultation and communication skills improved a great deal. At these seminars we had the benefit of a very senior and experienced psychoanalyst as the group leader, who helped us to discuss all the aspects of the case. During the time of my attending the seminar we also studied the pattern of referral to the hospitals, accidents and injuries. In the group we mainly discussed the patients who had psychological problems, but during the course of the discussion we also had the chance to see the recent developments, and evidence-based medicine as the discussion of the case progressed and the way it unfolded. In my mind I cannot think of any better form of supervision than these seminar's, where your management of the case is scrutinised, the presenting doctor is grilled, and applauded as well for some innovative ideas.

It is sad to note that these Balint groups are virtually defunct. Perhaps we have moved very fast with modern technology that doctors do not understand their patients, let alone the illness.

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Short screening tools for depression

We read with interest the recently published paper on pooled analysis of ultra-short screening tools for depression.[1] In our view the issue of importance is the validity rather than the accuracy of the short screening test. A high false-positive rate is not as important an issue in initial screening for depression as it is when screening for conditions that require invasive investigations to establish the diagnosis (for example carcinoma of the breast). A few more questions is all that is required to establish a diagnosis of depression and then offer treatment. The authors refer to our more recent tool, the two questions with help question (TQWHQ).[2] A positive response to either depression question plus the help question gave a sensitivity of 96% and