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

by the public. At that time, we should have pushed for an expansion of the number of principals, so that we could have continued to look after our patients holistically, and with continuity. We would also have coped better with the inevitable workload caused by an ageing society, increased population, and medical advances.

The profession is now becoming much less valued by the public, with satisfaction rates for GPs reportedly now down to 65%. It was always over 90% in earlier years. Cynics might say that this is what the Department of Health and Social Care want, as they cannot reform as they would wish while the doctors are popular.

In my early years I felt that the profession washed its hands of poor practice, and this is one of the reasons why reforms came in. We accepted poor practice often, in disadvantaged areas, where so-called 'decent' GPs' wouldn't want to work. As we did not put our house in order, it gave the neoliberalists an excuse to do it for us.

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Safety netting and follow-up (of babies' eyes)

The letter by Thomas Weatherby[1] comes close to a legal ruling following the tragedy of a child who went on to develop herpes encephalitis after an eye infection. Sticky eyes in babies are common. Red eyes and photophobias (eye not opening) are rare. The point I would like to make is that in the lawsuit one of the failings was lack of safety netting (or documented safety netting) after the child was first seen in hospital. Though the 'case' was some years ago and safety netting is practised much more now, as is the need to document this advice even more so, it is still worth re-enforcing the point. As GPs, most things we see run a benign course, but a tiny, unpredictable minority won't so in ALL consultations this safety netting needs to be specific, shared, and documented.

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Social prescribing in ethnic minority communities

Social prescribing reinforces a holistic approach to health. Benefits include improved fitness, motivation, and confidence to maintain better health, alongside reducing the burden of polypharmacy.[1] Unfortunately, there remains a recognised deficit in referrals for ethnic minority patients to social prescribing schemes.[2] Social prescribing may not have the desired outreach to British Asian and minority ethnic groups because of cultural, religious, and language barriers within social prescribing projects that prevent these schemes from being diversity friendly.[3]

As a result, there arises a need to ensure certain projects are designed with ethnic minority communities as the key stakeholders in an effort to encourage these groups to access social prescribing. Interestingly, charitable organisations and cultural groups have the necessary resources and a deeper understanding of their local populations to benefit the health and wellbeing of their communities.[4]

As a team at Sampad Arts, a heritage organisation based in inner-city Birmingham serving the local South Asian population, our latest project aims to address these inequalities by instituting a social prescribing event aimed at ethnic minority groups. Organisations like Sampad have the machinery to overcome those cultural barriers that prevent access to social prescribing, which consequently improves the implementation of projects in those communities that are isolated from these schemes.[5] Ultimately, working with organisations that have a greater knowledge of their communities will lead to the development of projects in a culturally sensitive manner.

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Corrections

In the editorial by A'Court C, *et al*, COVID-19 and cardiac considerations in the community, *Br J Gen Pract* 2021; DOI: https://bjgp.org/content/70/700/524; the Figure 1 caption incorrectly stated: 'COVID-19 is defined by an acute rise and fall in cardiac troponin.' It should be 'Acute myocardial injury in COVID-19 (defined by an acute rise and fall in cardiac troponin)', as shown within the body of the Figure. Figure 1 caption now reads 'Possible mechanisms and clinical manifestations of acute myocardial injury in COVID-19. MI = myocardial infarction. ACE-2 = angiotensin converting enzyme 2. The online version has been corrected.

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In the article by Margham T, *et al*, Reducing missed appointments in general practice: evaluation of a quality improvement programme in East London, *Br J Gen Pract* 2020; DOI: https://doi.org/10.3399/bjgp20X713909; in the Method, Setting, second paragraph 'Application Programming Interface' should be 'Approved Provider Interface'. The sentence now reads: 'All practices in the CCG use the EMIS Web clinical system and have access to Edenbridge Apex, a business intelligence and data visualisation platform with an Application Programming Interface with EMIS Web.'. The online version has been corrected.

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