

diagnostic behaviour within consultations was the frequency with which patients had previously consulted their GP.<sup>2</sup> The more frequently the patient had been seen in the previous year, the more likely the GP was to diagnose a mental disorder. A second variable found in our research was the presence or absence of disability in the patient.<sup>3</sup> GPs were less sensitive to the presence of mental disorders if there was little concomitant disability, and in sub-threshold cases, the presence of disability increased the chance of GPs identifying clinically significant symptoms.

In general practice, the “new patient” is a different kind of case than the frequent attendee. Similarly, a patient diagnosed with depression who is seriously disabled is a different kind of case to the more common kind found in general practice — namely, a patient diagnosed with depression but with little or no disability. It would not be surprising if Wilhelm et al were to find that among the 20% of patients overall in whom GPs identified psychological problems, many were “typical cases” seen by GPs — namely, frequent attendees and those with disability.

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## What can alert the general practitioner to people whose common mental health problems are unrecognised?

Marjan Kljakovic

**TO THE EDITOR:** Wilhelm and colleagues falsely concluded in their recent study that general practitioners in metropolitan Sydney and rural New South Wales had a low rate of recognition of psychological problems overall.<sup>1</sup> Furthermore, Wilhelm et al took GPs' judgements of the presence of psychological problems as the benchmark for “caseness” because of the difference between GP practice and psychiatric practice in the process of assessing psychological problems in consultation. My disagreement lies with what the researchers meant by “overall” and by “caseness”.

The rate of recognition of caseness of psychological problems by GPs will vary according to the nature of the cases under consideration. In their study, Wilhelm et al found that they had complete data on 76% of their patients. Our work in New Zealand found that a major variable that influenced

the presence of somatisation. We think the 12-item Somatic and Psychological Health REport (SPHERE-12) is a useful instrument, but that it has an intentionally low “caseness” threshold and needs to have some other tool to increase clinical relevance.

Kljakovic also comments on our use of GP judgement as a benchmark for caseness. The thrust of our article was to see how GPs make judgements and which of three different types of screening tool may assist them. This is not to say that GP judgement is an overall “gold standard” for caseness in an epidemiological sense.

It is certainly true that new patients are very different from those who are frequent attendees and/or well known to the GP. The screening tools are probably more useful in the first instance or when there is a change in the patient's mood. However, we wished to test these measures across the range of people seen by each GP, and the individual GPs were given the results from their own practices. The feedback from GPs was that these tools did prove helpful in drawing their attention to people they already knew about and also in identifying some that they did not. Such screens can also save time by ensuring that certain questions are routinely asked and responses are tracked, so the GP can see the results, reflect on them, and go on to ask other questions that build on this information, helping to make better use of the “face to face” time rather than having to run through them in the interview.

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1 Wilhelm KA, Finch AW, Davenport TA, Hickie IB. What can alert the general practitioner to people whose common mental health problems are unrecognised? *Med J Aust* 2008; 188 (12 Suppl): S114–S118. □

- 1 Wilhelm KA, Finch AW, Davenport TA, Hickie IB. What can alert the general practitioner to people whose common mental health problems are unrecognised? *Med J Aust* 2008; 188 (12 Suppl): S114–S118.
- 2 Bushnell J; MaGPIe Research Group. Frequency of consultations and general practitioner recognition of psychological symptoms. *Br J Gen Pract* 2004; 54: 838–843.
- 3 Collings S; MaGPIe Research Group. Disability and the detection of mental disorder in primary care. *Soc Psychiatry Psychiatr Epidemiol* 2005; 40: 994–1002. □

### Kay A Wilhelm

**IN REPLY:** I must apologise for the inclusion of a comma in the first sentence of the conclusion in our article's abstract, which changes the sense of the sentence.<sup>1</sup> That was my oversight. It should read “Low rates of recognition of psychological problems by GPs [general practitioners] and infrequent treatment for those presenting with somatic symptoms...”, meaning that there are low rates of recognition and treatment in *patients with somatic symptoms* rather than in patients overall. We were reflecting the need for more recognition of how to deal with depression and anxiety in