Correspondence

Inner-city general practice population with schizophrenia

Sir: Blair & Deaney (*Psychiatric Bulletin*, April 1998, **22**, 221–225) give an enlightening view of the care of people with schizophrenia within primary care. They speculate on the difficulties of coordination of care and suggest realigning services so that community mental health teams (CMHTs) became "more practice sensitive".

We have adopted this approach within Pathfinder Mental Health Trust in Wandsworth and Merton for some time now. Initially introduced in Wimbledon in 1986, it proved invaluable in setting up a time efficient and durable monthly liaison meeting between team and practices (Midgley *et al.*, 1996, Burns & Bale, 1997). As a result of this experience (and of a survey of general practitioners' (GPs') view of our services conducted in 1995) 'practice alignment' was introduced across all nine of the general adult teams in 1996. The result is easier and more effective communication, better mutual understanding of strengths and weaknesses and a range of shared care that reflects the individual competencies of those involved. A further review of GP opinion in early 1998 indicated significantly improved satisfaction with our services.

Achieving GP alignment is not easy, nor is it problem-free. The transfer of care took over a year and was disruptive for many patients and their keyworkers. The complexity of some of the arrangements (three way swaps, etc.) has to be experienced to be believed and not all teams or practices could move at the same pace. Sensible policies for exceptions such as patients with no GP, are in transit between GPs (often a sign that something dramatic is on the go) or who are living with their mother and consulting one GP while being registered with another etc. require tolerance and some ingenuity. Patients served by each CMHT are now more widespread, noticeably increasing travelling time.

We experimented with one group practice to include patients resident in the neighbouring borough and the results were not good. Problems consistently arose both in coordination of long-term health and social care and in emergency procedures. After several months of trying, both the GPs and CMHT agreed that it is not a sensible option. Would it be so outrageous to suggest in our new primary care-led National Health Service that the time has come for GPs to change on this one? In urban settings surely primary care should start to move towards co-terminosity with health authorities and social services.

Blair & Deaney's considerations of the optimum integration of GPs with CMHTs (and social services) are particularly important and timely as we approach the planning for primary care commissioning groups.

BURNS, T. & BALE, R. (1997) Establishing a mental health liaison attachment with primary care. *Advances in Psychiatric Treatment*, **3**, 219–224.

MIDGLEY, S., BURNS, T. & GARLAND, C. (1996) What do mental health teams and general practitioners talk about? Descriptive analysis of liaison meetings in general practice. *British Journal of General Practice*, **46**, 69–71.

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Proposed reforms to civil justice

Sir: Psychiatrists offering their services as expert witnesses must be aware of the proposed reforms to civil justice. If these reforms, which suggest fundamental changes to the very structure of civil litigation, succeed experts will face greatly changed demands.

For example, legal aid looks set to become a licensed service with only 'franchised' firms permitted to undertake legal aid work by January 2000. Those experts wishing to work on the much-reduced volume of legal aid cases will need to be listed as 'approved' by franchised firms. Experts may well be asked to agree to lower or much-delayed payment for this 'privilege'.

Furthermore, the Government's proposal to control legal aid costs by removing monetary claims from legal aid is contingent upon successfully increasing the scope of conditional fee arrangements (CFAs). This means expert witnesses will face increasing pressure from some solicitors to accept work on a 'no-win', 'no-fee' basis. Some practising solicitors believe the only feasible way for them to undertake work on a no-win, no-fee basis is if experts agree to share the risks. However, most individual experts, the Society of Expert Witnesses and the Law Society are united in their rejection of contingent payment terms for experts because they would fatally wound the expert's claim to impartiality.

However, CFAs may also mean more work for experts, who can expect to be asked for advice in the early stages of risk assessment undertaken

by solicitors contemplating a CFA. In these cases, accurate risk assessment is essential to the solicitor, particularly because after-the-event insurance is currently available for only a very specific category of personal injury cases. At this stage, insurers are unclear about how they can expand the existing system to cover other types of case, meaning that solicitors who choose to accept those cases must run them bare of insurance.

Given the problems potential litigants now face with the court system, alternative dispute resolution (ADR) methods are increasing in popularity. ADR offers several alternatives to traditional court methods and a number of opportunities for expert involvement. Within the scope of ADR, experts can act as advisors or offer expert appraisal of a technical issue. Parties may also agree to an 'expert determination', where an expert rules conclusively on the issue for them, or ask the experts to take on the role of mediator.

Experts interested in obtaining further details can contact the Society of Expert Witnesses on (0345) 023014 or write to PO Box 345, Newmarket CB8 7TU.

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Health of the Nation Outcome Scales for People with Learning Disabilities

Sir: Further to the publication of the original paper 'HoNOS in long-stay patients with learning disabilities' (*Psychiatric Bulletin*, May 1988, **22**, 306–308), we are writing to keep you informed of recent developments with regard to the piloting of the Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD).

HoNOS-LD is the result of a collaboration between the Department of Health, the Royal College of Psychiatrists and the Centre for Outcomes, Research and Clinical Effectiveness (CORE) at the British Psychological Society, University College London. Like the generic HoNOS, HoNOS-LD is a set of scales designed to measure outcomes in a population of people with mental health needs. It retains the five-point scale of severity of problems, but has greater context reliability with regard to the associated needs of the client group. HoNOS-LD has 18 items, is designed for people irrespective of their degree of learning disability and should be used by trained professionals.

North Warwickshire National Health Service (NHS) Trust has allocated resources for the post of Regional Clinical Audit Coordinator who has responsibility for training, data analysis and dissemination in an area north of a line from the Wash to the Bristol Channel, while CORE have employed a researcher to take responsibility for the same in participating trusts in the south.

Following a training day, agreement was reached that HoNOS-LD would need to be tested rigorously for interrater reliability and sensitivity to change. Version 2 is currently being piloted at over 20 sites (all NHS trusts) throughout the United Kingdom.

It is expected that data analysis will have been completed in Autumn this year and, if the instrument is demonstrated to have acceptable reliability, will be made available by the Department of Health for use in routine clinical practice for people with learning disabilities and mental health needs.

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The practice of evidence-based journal clubs

Sir: Geddes (*Psychiatric Bulletin*, June 1998, **22**, 337–338) states that an evidence-based journal club (EBJC) presentation can be prepared in two hours. This may be the case at the centre for evidence-based mental health in Oxford, but here in Britain's most northerly department of academic psychiatry we struggle to believe it. Perhaps our remoteness from such a centre of excellence slows our thinking, but we do not see how the process can be effected in such a brief time.

In Aberdeen we recently introduced an EBJC linked to the weekly case conference and we encourage junior staff to present. We find the preparation process takes considerably longer than Geddes allows, for several reasons. Many presenters lack experience in critical appraisal and require individual mentorship, not always available through their weekly educational supervision. The authors act as mentors, taking particular responsibility for helping trainees develop the required skills.

The clinical question is set three weeks ahead of the session by the consultant presenting the case and it is helpful for a mentor to be involved. The presenter requires guidance in the process of searching the literature databases and deciding which papers to select. Obtaining papers not held locally may take some weeks. Critical review may involve the trainee having to ask others for assistance in assessment of study methods, particularly statistics. Finally, the presenter needs to prepare materials and may wish to rehearse their presentation.