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.

Incapacity benefit claims: a general practice study

Sir,

In April 1995 the 'fitness for all work test' was introduced.[1-3] Claims are initiated by a GP-completed Med 4 certificate and a subsequent medical examination by benefit agency doctors, except for those exempted (e.g. those with severe mental illness). There can be significant financial gain for the claimant in receiving incapacity benefit over the jobseeker's allowance. Those on sickness benefit are not required by the agency to actively seek work.

We wanted to see whether those who 'failed' the DSS medical test for incapacity benefit subsequently presented themselves to their doctor in an attempt to requalify themselves for sickness benefit. Records in a large inner-city general practice (13 500 patients), characterized by a high level of social disadvantage, unemployment, and chronic illness, identified 171 patients (62% male) who were given a Med 4 between April 1995 and October 1996. The computer and paper records were searched for information on the nature of the patients' problems, consultation rates for the year before and after the claim, and its outcome, which was recorded in the notes of 124 patients (73%). The Benefits Agency, at that time, did not inform the GP of the result of the claim. We sent a brief postal questionnaire to the 64 patients who had not passed on their result to the GP; 21 replied. The Benefits Agency has subsequently changed this policy and now routinely informs certifying GPs about the claim outcome. [4]

The primary disabilities among the sample were those caused by musculoskeletal problems (32%), other physical problems (28%), psychiatric problems (24%), and substance misuse (16%). Seventy-eight patients were under the age of 40, and 59% of them had psychiatric or substance misuse problems, compared with 29 (41%) of the 90 patients over 40 years ($\chi^2_1 = 7.11$, $P = 0.0077$). Among the 124 patients with known claim outcome, 87 (70%) were found to be incapable of work. There was no relationship between sex and claim outcome, but those over the age of 40, or those with psychiatric or substance misuse problems, were significantly more likely to receive incapacity benefit. Patients with a relatively greater consultation rate were more likely to be awarded incapacity benefit. No subsequent rise in consultation rate was found among those whose claim was unsuccessful. Future research will need to be directed prospectively at larger samples, so that firm conclusions can be drawn.

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The willingness of GPs to work with alcohol and drug misusers

Sir,

Although we welcome the paper by Deehan, Taylor and Strang (November *Journal*)[1] as an addition to the debate on how GPs perceive drug and alcohol misusers, we would like the results to be viewed with an air of caution.

There are several reasons for this caution, the first being that general practice has quesionnaire-itis! In November 1997 alone, practices in this area received about 12 questionnaires. Most of these took time to complete and many implied more work for general practice. Therein lies the second reason for caution. General practice is being 'forced' to change, and practitioners often feel reluctant to take on more clinical and administrative work. The third reason for caution should be that we often respond differently to the idea of more work when training and support are also offered. In the Deehan questionnaire, only 10% of GPs felt confident in their ability to treat substance abusers, but a healthy 24% of GPs would be encouraged to work with drug users if they had more training, and a further 19% were uncertain.

We run a training and support scheme for GPs to work with drug and alcohol users. More than 100 GPs (about a third of the local GPs) had attended some training on drug and alcohol awareness. Almost all have reported an improvement in detection of these problems and a greater willingness to work with these groups of patients. Substitute prescribing for drug users has increased from four GPs to around 40, and continues to increase. Understanding that there are many positive things a GP can do other than 'cure' is cited as the most common reason for this change (Ford C, Barjolin J-C, unpublished data).

Our experience is not unique, and there are now many schemes training supporting GPs that have led to greater involvement and increased confidence.[2,3,4]

The fourth reason for caution regarding this study is that questionnaires are not about real people that we know. We have found that when GPs are asked if they would take on a patient who lives in their area, or the prescribing for a patient who is

already registered, they are often willing to do so. The local specialist services have long been clogged by stable users on low-dose maintenance who can be appropriately treated in the community. We are attempting to return the prescribing for stable drug users to the community. This can also allow specialist services to focus on the more complex interventions and the stabilization of patients prior to GP management.

Our experience has been that, with the right support and encouragement, primary care can respond 'to the challenge of treating this disenfranchised group'.[5]

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Weighting for GMS cash-limited allocations

Sir,

The appropriate basis of remuneration in general practice has been debated since the original GP contract in 1965.[1,2,3] While an appropriate remuneration system should be related to effective performance,[4,5] specifying outcome in primary care is difficult,[6,7] and most commentators have therefore focused on the measurement of workload.[1,4,8] The introduction (in 1985) of the Jarman deprivation payment[9] was indeed intended to reflect the presumed greater workload engendered by patients' lists drawn from deprived areas — although the basis of the Jarmen index is hotly disputed.[10]

Although this debate preceeded the advent of the new GP contract in 1990, the issues are even more pertinent today because the basis of the general medical services cash-limited allocations has recently been changed to reflect the different casemix presented by different age groups based on estimates of the average lengths of consultations with GPs in the different ICD (International Classification of Diseases) chapters.[5] This is a curious procedure because the bulk of that component of the budget (70%) is for practice nurses; to adjust that proportion of the budget for workload it would seem better to examine the casemix presented to nurses.

However, there are good grounds for querying the whole approach. One could argue that the basis of any package should be need and not raw demand or (unadjusted) utilization so that, for example, a male adolescent from a deprived environment (a 'putative' low and brief consultor) may have greater 'needs' than an introspective middle-aged woman from suburbia (a 'putative' high and lengthy consultor) for whom regular visits to the surgery are part of her 'routine'. This is the approach adopted elsewhere in the resource allocations literature and is the basis for the other formulae implemented or proposed by the Executive.[5] The departure from this generally agreed approach, which is implied by this weighting, should be re-examined.

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Depression screening instruments

Sir,

We are aware that depression still represents a significant public health problem in general practice, and that screening instruments designed to detect symptoms of depression could have important benefits for recognition, greater patient well-being, and cost savings. A number of self-rated questionnaires are available that could act as screening instruments for depression, but they have not lived up to their promise. Some questionnaires require additional assessment after screening to ensure the diagnosis is correct, some are long and are not sensitive to somatic presentations of depression, and none give specific guidance on management.

We have been reviewing the literature concerning these screening measures during our development of a new self-rated 'brief depression scale' (BDS) specifically designed for use in primary care. Although a number of excellent reviews are available,[1] there are still difficulties to be overcome in using these instruments to detect depressive illness in the surgery. Specifically, many of these questionnaires, although showing good validity results, still do not make it possible to predict with reasonable certainty a diagnosis of depression by current diagnostic criteria. This is essential in order that patients with a reasonable chance of showing improvement after treatment will be detected as suffering from a definite depressive illness. Many of the currently used screening instruments, including the well-known Beck depression inventory and the Zung Sscale, were not designed as screening instruments at all, but as measures of the severity of depression once recognized. This has led to problems of interpretation in a number of research studies.

Notwithstanding many practitioners' efforts in improving detection of depression in their surgeries,[2] we offer the following guidelines for the future use of these scales in primary care:

- Screening scales should be easy to administer and use and should be able to detect clinically relevant depressive disorder as opposed to unhappiness.
- It is important that scales are able to detect somatic symptoms of depression as this is the most common way in which the illness presents to the general practitioner.
- Scales should be detection or diagnostic instruments rather than severity measures.
- Scoring should enable relevant management decisions to be considered, perhaps by the use of protocols used