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’.

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References

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. While an appropriate remuneration system should be related to effective performance, specifying outcome in primary care is difficult and most commentators have therefore focused on the measurement of workload. The introduction (in 1985) of the Jarman deprivation payment was intended to reflect the presumed greater workload engendered by patients’ lists drawn from deprived areas — although the basis of the Jarman index is hotly disputed.

Although this debate preceded 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. 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 consultant) may have greater ‘needs’ than an introspective middle-aged woman from suburbia (a ‘putative’ high and lengthy consultant) 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. 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, there are still difficulties to 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, 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

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