

choose to hear, or want to hear: GPs' opinions may have been more equivocal than families state! But it would be greatly appreciated if GPs could make the time to obtain and read the Continuing Care criteria, so that they are in a position to give as informed a view as possible regarding this important matter. We have a shared task, to ensure that those who are eligible for the full funding of their care are enabled to obtain this help as speedily and as easily as possible.

Jane Reynolds

Chairman, Continuing Care Review Panel,
North East London Strategic Health Authority
and South East London Strategic Health
Authority, 33 Carlton Mansions, Randolph
Avenue, London W9 1NP
E-mail: janereynolds@onetel.com

REFERENCE

SAGA magazine, January 2005.

Prescribing to substance misusers

I must strongly disagree with Stephen Willott's opinion¹ that it is 'good news' that there has been an almost threefold increase in the number of GPs seeing opiate users.

If there had been an increase in the proportion of substance misusers seeing GPs and having specific treatment (from someone) that would be good news.

The possibility of a real increase in the number of misusers would most definitely be bad news, whether or not they were seeing their GP!

Again, increase in proportion treated (regardless of numbers) would be good news, but that they are treated by inexperienced non-specialists would not necessarily.

An increase in the number of GPs seeing these patients, even if the total patients stays the same, would imply that they are being more thinly spread across non-specialist care, and this suggests to me that their care is being dumped on inexperienced GPs who do not have the support to manage them well.

This would most definitely not be good news for the patients or the community.

It is also quite possible that they are indeed being dumped without the

provision of any local enhanced service support, and this would be bad news for the GPs involved, who are doing it for free, as well as without support.

I don't know where Stephen works, but here in our part of Wales we have very poor availability of service, partly related to rurality, but the hospitals do tend to discharge such patients with instructions to get scripts from their GPs for tomorrow's doses, with no thought as to the effects of this on GP services or quality of care, and the fact that we have no contract to provide such services. Furthermore, when informed of their duty to continue prescribing, the hospital staff seem to think it is okay just to dump it for GPs to sort out, when we don't even have access to a suitable dispensing chemist for some of these drugs nearby, let alone education and an LES for the service.

Could Dr Willott influence this service provision problem at all to improve care of these patients?

David Church

GP, Machynlleth
E-mail: David.Church@gp-w96014.wales.nhs.uk

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Mental health screening may prove effective in primary care

A recent study by the MaGPIe Research Group¹ demonstrated high GP recognition rates (70.3%) of mental health problems. The findings may, however, be biased by the fact that GP case identification was based on a historical 12-month observation period whereas the final diagnosis (CID) was a present state assessment (within 1 month). This could lead to an overestimation of GP recognition rates. The conclusion that there is little gain from screening due to high detection rates may therefore be erroneous.

In a study using a composite screening questionnaire^{2,3} we found that 43% of patients had high screening scores. Among patients with high screening

scores we found an NNT (number needed to test) of 5, indicating that feedback on high scorers has the potential to identify 20 new cases per 100 cases. The effectiveness of feeding back high scorers' results on depression and anxiety scales is supported by a systematic review by Gilbody and colleagues.⁴ A clinically useful description of this high score group could provide us with suggestions for making rational use of rating scales in general practice. While there is little evidence to support routine mental health screening, case-finding seems most promising.⁵

Kaj Sparle Christensen

MD, Research Unit for General Practice,
University of Aarhus, Denmark
E-mail: kasc@alm.au.dk

Frede Olesen

MD, University of Aarhus

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Impact of obesity

The Counterweight Project Team documented the obvious in their paper 'The impact of obesity on drug prescribing in primary care':¹ physical activity and weight loss produce better health and save money of the tax payers.

In the US, CDC has estimated that a sustained 10% weight loss will reduce an overweight person's lifetime medical costs by \$2200–5300 by lowering costs associated with hypertension, type 2 diabetes, heart disease, stroke and high cholesterol.

This does not take into account other resources consumed by problems such as orthopaedic related issues.