Rapid Responses published:

Screening for mental disorders: Practices and policies under the rug
Carmelo Vazquez (28 April 2006)

QOF and screening
Dave Syme (28 April 2006)

Re: QOF and screening
Daniel I Jefferson (4 May 2006)

diagnosis of depression and screening
manjeestha das (5 May 2006)

Treatment of people with depression in a primary care setting
Helen E Lester, Dr Alan Cohen, Professor Christopher Dowrick, Professor Linda Gask, Professor Tony Kendrick, Professor Glyn Lewis, Professor Debbie Sharp, and Professor Andre Tylee (10 May 2006)

Re: Should We Screen For Depression
Lizzie Marsh (12 May 2006)

Screening for mental disorders: Practices and policies under the rug

Carmelo Vazquez, Professor of Psychopathology; School of Psychology, Complutense University, Madrid, Spain.

Send response to journal: 28223-Madrid (Spain) Complutense University / School of Psychology / Psychopathology

The paper by Gilbody et al. (BMJ 2006; 332: 1027-1030) is a serious contribution to the debate on the risks of universalization of the disease model. To promote screening practices affecting large populations could be defensible when cheap and accessible treatments are available but, as the authors state, the existing data do not allow concluding that the screening of depression can contribute, by itself, to enhance the quality of care of depressed people. Screening policies and practices (e.g., selection of cut-off scores in tests of depression) should also be understood in terms of the social and economic fabric of our times. In fact, the situation in many Western countries is that the care of depression is increasingly being put in the hands of primary care doctors rather than in those of mental health specialists. In the case of Spain, according to data from the National Health System (NHS), in the last 10 years, the consumption of psychotropic medication has increased by 1.5, whereas the cost of this medication for the NHS has been multiplied by 3.08. One of the effects of this emerging pattern of spectacular increase in the economic benefits of psychoactive medication, is that the pharmacological industry is putting tremendous pressure on primary care practitioners to screen and assess depression to ultimately treat that condition with the only means that doctors usually have (i.e., antidepressants). Therefore, screening policies should be carefully examined, not only as part of a scientific debate, but also in terms of their use in specific social, professional and economic contexts.

Competing interests: None declared

QOF and screening

Dave Syme, GP, Alnwick, Northumberland, 4 May 2006

Send response to journal: 4 May 2006

I'm surprised that the authors and the BMJ suggest that GPs will be rewarded under the QOF for "screening" for depression. I can't find a reference to support this contention. My understanding is that GPs will be asked to use a scoring system as part of their diagnostic process for depression, which may or may not make the diagnosis more robust but will certainly make it more bureaucratic.

Competing interests: None declared

Re: QOF and screening

Daniel I Jefferson, Dr, GP
Alnwick, Northumberland, NE7 7JX

Send response to journal: 4 May 2006

The QOF criteria this year are very specific for depression. All patients with diabetes and heart disease are to be screened using two screening questions.1 These questions originated from the PRIME-MD patient health questionnaire, as did the PHQ-9.2 In addition, all new cases of depression should be categorised as mild, moderate, or severe. This is suggested to be done by using a scale such as the PHQ-9 or the HAD. Perhaps more robust is the suggestion by NICE to use the ICD-10 criteria for diagnosing depression.3

The important point is that once many new cases have been identified, there is no extra provision for managing them. I allude to this in my reply to Lord Layard`s article- this is on the BMJ website "The case for psychological treatment centres"?

4 Interestingly, there is no evidence to show the need for psychological treatment centres, in addition they will not help with the need for extra provision for patients with depression in the here and now.

3. NICE guidelines for depression
4. Jefferson D, "The case for psychological treatment centres"? BMJ website

Competing interests: Funding from Wyeth for a CBT course

diagnosis of depression and screening

manjeestha das, 5 May 2006

Competing interests: None declared

http://www.bmj.com/cgi/letters/332/7548/1027 06/02/2007
I fully agree with the comment by the author “Depression is common in patients in primary care and hospital settings but often is not recognised by healthcare professionals.”

Being SHO in Psychiatry at times I really miss the opportunity to see the patients with mild depression who are mostly managed in primary care. Thus I am not sure how good I am to recognise the subtle signs of depression in milder cases which is not only a common primary mental illness but also quite common comorbidity with other chronic illness such as Diabetes or Hypertension etc.

Moreover because of the emphasis on community based management of mentally ill patients and shortage of psychiatric beds in hospitals obviously there is very little opportunity for admission of these mildly depressive patients. Though personally I feel at times these short stays are very helpful in the long term, not only for the patients in the form of ‘early diagnosis and active management’ but also for us as trainees, who get better experience of diagnosis and outcome, which is so important is Psychiatry because this is a science which totally depends on clinical skills for diagnosis rather than depending on any investigations. Thus by improving the clinical skills for diagnosis it can addresses a very important aspect of any screening programme specially in Psychiatry.

Competing interests: None declared

Treatment of people with depression in a primary care setting

10 May 2006

Editor

We were pleased to see the prominence given to the issue of depression in the 29th April edition of the BMJ. (1)(2)(3) As each of your contributors points out, depression in primary care is costly on a number of different levels. However as a group of practitioners with both clinical and research interests in primary care mental health, there are a few comments we feel compelled to make.

Professor Scott(1) highlights the need to consider depression as a chronic disease. However her suggestion to develop a shared care approach with secondary care will only apply to a minority of patients as the majority of people with symptoms of depression can be managed solely within primary care. Indeed, of these, many are experiencing a self-limiting disturbance which does not require medicalisation.

Gilbody et ai(2) correctly suggest that a national screening programme for depression does not meet recognised criteria. However they miss in their assertion that the Quality and Outcomes Framework (QOF) is now rewarding GPs who screen for depression. QOF in fact incentivises annual case finding for depression in people in the diabetes and coronary heart disease registers (groups with a more than 30% risk of developing depression)(4)(5) and the use of a severity measure in patients where a diagnosis of depression has been made. The NICE guidelines on depression recommend looking for depression in high-risk groups and different treatment options for mild than for moderate to severe depression. A measure of severity in diagnosed cases is therefore critical in ensuring good quality clinical care. Encouraging GPs to use an instrument that measures the severity of depression may also add another phase to the interaction between doctor and patient, one that may encourage both to reflect on the best treatment options.

Professor Layard suggests that an extra 10,000 therapists by 2013 will improve access to psychological therapies and provide evidence based cost effective care.(3) This is particularly welcome since the waiting list for psychological interventions can be many months. However the recent chequered history of implementing similar roles (for example the graduate primary care mental health workers) leads us to believe that his target may be unrealistic.

Perhaps an overarching message of these articles is that we are still unclear about the optimum way to treat people with depression in primary care. This underpins the need to continue to commission high quality research in this important area.


Competing interests: All authors contributed to the report on possible depression indicators in the Quality and Outcomes Framework (QOF) 2006.

re: Should We Screen For Depression

12 May 2006

Sirs,

I read your article with interest. I have no medical background whatsoever, so my views are not in any way based upon any particular way of thinking. I have no bias as such, other than an instinctive and hopefully, well reasoned response to your piece.

First of all, it is refreshing that you publish with a view to foment discussion - all too often this is not the case and we, the general public have little choice but to accept yet more government/medical advice that is supposedly in our best interests. Says who?

With regard to your question: personally, I do not think that screening for depression is a good idea, or that it would be beneficial, except to those who seek to understand the complexities and workings of the human mind; which a national screening programme would undoubtedly lead to, rather than having a beneficial effect on those for whom it is intended.

One must ask: why? What would be the purpose of such a programme. Prevention is better than cure, I hear. But prevention of what? It seems to me that, in the US and the Western world particularly, there is an endless obsession with prevention...which in some or many cases is right and proper and this constitutes progress.

However, there is a world of difference between the physical and the mental well-being of an individual or a people and it is this that I find somewhat alarming. When something as wide-ranging as screening for depression is suggested, whilst there will always be some merit in any kind of research I would question/challenge any form of mental intrusion.

What I would prefer to see is a study on the causes of depression, rather than a study on depression itself. As soon as one begins to "tamper" with the workings of the mind, albeit with altruistic motives, it is almost as if the genie is being let out of the bottle.

If we are to assume that at some point in time, screening occurs, what then? What does the medical fraternity do with the knowledge it now has that "potentially" there are all kinds of people out there who "may do.....".
Unfortunately, we then enter into the realms of pseudo-science with whatever analysis may be gleaned that appears to indicate a leaning one way or another on a scale of 1 - 10. The terrible reality exists that what started off as a well-intentioned piece of medical research could become a tool with which the state/medical profession etc. uses as a means of manipulating those of the population who appear not to fit as proscribed. Surely the purpose of our individuality is precisely the opposite - that we do not fit, that each of us are different, unique, etc.? Whilst I recognise that research will always be of a pioneering nature, I do believe we must use any knowledge we have wisely. If a study is to be done, would it not be better to exercise caution when the prevailing view is that the public would not be receptive?

I cannot help but sense that whilst the authors are terribly well-meaning, to ask a question such as this sounds awful for those who look to doctors for advice/support/help etc. It may be obvious that depression is all around us in our society but I do not believe the answer or solution to this issue is to probe ever deeper into the human mind but to look outwards, for when one does, the outlook becomes positive.

Competing interests: None declared