Niels Okkels, B.Sc.
Niklas Alexander Worm Andersson, B.Sc.

The authors, who are medical students, are affiliated with Department of Organic Psychiatric Disorders and Emergency Ward, Aarhus University Hospital, Risskov, Denmark. Mr. Andersson is also with Sydney Medical School, University of Sydney, New South Wales, Australia.

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Low Depression Screening Rates in U.S. Ambulatory Care

To the Editor: Depression is an important public health problem with significant costs both to individuals and society. In 2003, the U.S. lifetime prevalence of major depressive disorder was 16.2% (1). Depression is the leading cause of disability (2), with an estimated cost of $83.1 billion in the United States in 2000 (3). As of 2009, the U.S. Preventive Services Task Force (USPSTF) recommends "screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up" (4). In light of these recommendations, the primary aim of the study reported here was to estimate the rate of depression screening in the U.S. outpatient office setting.

The National Ambulatory Medical Care Survey (NAMCS) is an annual cross-sectional survey of visits to office-based physicians across the United States, stratified by physician specialty (5). Approximately two of three sampled physicians participate in the survey. Depression screening at sampled visits is ascertained and recorded by the responding physician, a member of his or her staff, or a U.S. Census Bureau field representative who reviews medical records for documentation of the screening performed. Because information on depression screening was first collected in 2005, data from 2005 to 2010 were analyzed. The USPSTF does not support screening for children 11 years and younger. Therefore, only visits for patients 12 years and older were included. Visits to psychiatrists were excluded from the analysis.

SAS version 9.2 was used to analyze the data; SAS SVY PROCS was used to account for the complex survey design. Sampled visit weights were applied, which produced unbiased national estimates. The percentage of visits, overall and with primary care physicians (general and family practitioners, internists, pediatricians, and obstetricians-gynecologists), linked with depression screenings are reported with 95% confidence intervals (CIs).

Over the period, the average number of annual visits was estimated to be 947 million, and the average annual frequency of documented depression screening was 1.3% (CI=1.1%–1.5%). For visits to primary care physicians, the rate was 1.8% (CI=1.5%–2.1%). Screening was most common among internists (2.8%, CI=1.8%–3.8%), followed by gynecologists (2.4%, CI=1.3%–3.4%), family physicians (1.9%, CI=1.6%–2.2%), pediatricians (1.8%, CI=1.0%–2.6%), and other specialists (.5%, CI=.2%–.7%). Among visits for which no screening was documented, 7.7% (CI=7.2%–8.2%) were for patients who already had a diagnosis of depression.

The NAMCS has several limitations. It does not record whether sampled offices have adequate staff for screening and follow-up care. To our knowledge, the accuracy of NAMCS methods for identifying depression screening through chart review has not been confirmed. Because visits were the unit of analysis and physicians may screen patients only annually, the period prevalence of screening for patients over a year cannot be estimated.

Ultimately, depression screening rates are quite low and further steps are required for improvement. Depression screening itself can be as simple as asking two questions. Thus it is likely that screening may not be performed because the necessary follow-up care resources are not available at some offices. It is therefore important to develop a plan that improves access to depression management resources for outpatient offices.

Suzanne T. McGoey, M.D., M.S.
Karen E. Huang, M.S.
Guy K. Palmes, M.D.

Dr. McGoey and Ms. Huang are affiliated with the Center for Dermatology Research, Department of Dermatology, and Dr. Palmes is with the Department of Psychiatry and Behavioral Medicine, all at the Wake Forest School of Medicine, Winston-Salem, North Carolina.

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The Pedagogy of Recovery

To the Editor: In 2009, the United Kingdom's first Recovery Colleges

began to emerge in London and Nottingham. These were sites of teaching and learning, established on the premise that education can empower people with mental illnesses and compensate for the debilitating effects of traditional psychiatric care. Today, hundreds of students are enrolled in these Recovery Colleges, taking a wide range of courses to meet their specific needs and interests. In contrast to the traditional medical model that focuses on symptoms and deficits, an educational paradigm seems more consonant with the principles of recovery in that it focuses on building strengths and achieving goals. Among the many courses offered are creating positive relationships, introduction to stress reduction, and understanding the benefits system. In this setting, people in recovery no longer assume the role of the patient in need of treatment; instead, they are students in pursuit of knowledge, who have the support of instructors who understand what it is like to live with mental illness (1).

What is implicitly understood among proponents of Recovery Colleges—and what we make explicit in this letter—is that using a conventional education model does not necessarily engender recovery-oriented service provision. Paulo Freire (2) argued that education could be oppressive when teachers exercise intellectual authority over their students, such that students merely act as containers to hold the information deposited into them by teachers. This is what Freire referred to as the "banking model" of education, which prevents students from developing critical consciousness—that is, the ability to see their own oppression and emancipate themselves from the myths and ideologies set forth by the dominant class. Alternatively, Freire posited a more egalitarian model of education known as "problem-posing dialogue," which occurs when teachers and students exchange ideas and work collaboratively to coproduce knowledge that redresses the injustices of society.

Given the oppression experienced by people with mental illnesses, Freire's notions of pedagogy pertain to them. Unfortunately, this oppression often comes from a banking model of mental health services, where power resides in the professional staff who diagnose problems and prescribe treatment while the person in recovery relinquishes control and waits to be "fixed" (3). Although Recovery Colleges appear to promote problem-posing dialogue (courses are often coinstructed by people with mental illnesses), educators must be mindful of the power they can have over their students when the spirit of pedagogy does not allow people to find their own solutions to and to become experts at managing their own lives.

We find it useful to frame recovery as an activity of teaching and learning because doing so helps expand our roles as providers. We must see ourselves as teachers who can engage in dialogue with people in recovery—combining our professional experiences with their personal experiences living with mental illness—to inspire them to investigate their own problems, arrive at their own conclusions, and choose their own paths. But perhaps most important, we must learn to become avid students, because we often underestimate how much we have yet to learn and how much people in recovery have to teach us.

Hans Oh, M.S.W., M.Ed.
Jordan DeVylder, M.S.W.

The authors are affiliated with the School of Social Work, Columbia University, New York City.

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