Screening in primary care: pointers for further research

MEDICAL screening should be acceptable (before, during and afterwards) to as many as possible of those approached and should have a minimum of adverse effects whatever the outcome. Where results are positive, there should be optimal compliance with advice on treatment or change in behaviour. The relevant psychological issues have often been viewed in simplistic terms — with an over-emphasis on anxiety and a neglect of a wide range of other possible consequences for emotional state, health beliefs and behaviour.[1] Review of the current literature reveals inconsistent findings.[2] Some studies have found that screening is reassuring; others have reported anxiety, depression and health worries. These differences may be due to the different types of health screening, the measures used, the ways in which risk information is given, and the selection (and self-selection) of the screened population. Further and better research is needed in a wide range of clinical situations, and it is needed quickly.

A paper by Marteau *et al*[3] in this issue derives from the British Family Heart Study (BFHS), a very large cardiovascular screening and lifestyle intervention for men aged 40-59 years and their partners. The authors conclude that there was no evidence of adverse effects on perception of current health, but they also describe reductions in perceptions of cardiac risk and of the ability to reduce risk further, at one-year follow-up, in those who have made positive changes in risk factors. The study was not designed to examine psychological factors in detail, but it raises important general issues which go beyond the restricted assessments of mood, anxiety, knowledge and satisfaction used in most previous research. We need to know much more about how individuals respond to and cope with information about the risks of illness, especially as there is some evidence that it is difficult to change risk beliefs and even more difficult to change behaviour.[4] At least four important questions need to be addressed.

(1) Are we using the right psychological measures?

There is a marked tendency for those responsible for screening to assume that they understand patients' problems and anxieties. However, commonsense conclusions are often wrong; we need more research to find out from the subjects themselves what they think and feel about screening, and the ways in which it is provided and explained. To do this we need appropriately sensitive measures, chosen to cover the right aspects of psychological functioning. These go well beyond mood, anxiety and knowledge. They include beliefs, well-being and behaviour. The BFHS study is based on three simple questions with three- or four-point self-ratings. Clearly, these can hardly be expected to be sensitive to small but clinically significant changes.

Over-reliance on the simplest self-report measures of obvious aspects of mental state results from a lack of awareness by medical researchers of recent developments in psychometric instruments, and also from the lack of clinical experience by many psychologists. We need a more vigorous and informed collaboration between those with the methodological expertise and clinicians. Future research could gainfully make use of an extensive psychological literature on health beliefs, their relation to behaviour, and the effectiveness of interventions in experimental and clinical settings.[5] These stress patients' immediate cognitions (thoughts), their relation to underlying beliefs, and the ways in which they determine behaviour. Failure to understand the importance of individual cognitive processes (and indeed the beliefs of patients' families) may well mean that information and advice is misdirected and ineffective. Attempts to change behaviour without modifying family-held held but inappropriate beliefs is likely to be unsuccessful. This is but one aspect of the familiar clinical problem that providing didactic knowledge is a remarkably unsuccessful way of achieving successful doctor–patient communication. In this field, as in others, we must learn the lesson that there are much better ways of providing worthwhile information and advice. We therefore need to apply the practical techniques that have been used in proven cognitive treatments for anxiety, depression and a wide range of behavioural problems to modify maladaptive beliefs and changing behaviour.

(2) What about those who refuse screening and those who drop out of follow-up?

All screening programmes pose problems of acceptability. It may well be that those who might benefit most from screening and intervention are the least willing to take part. It is obviously essential to make screening convenient, to present it courteously and efficiently, and to provide results in a comprehensible and positive manner. This is not enough, however. Inevitably, in research and in clinical practice, there will still be both non-participants and those who do not complete any follow-up. Who were these subjects? What effect does the offer of screening or intervention have upon them? Solution of the problems of non-participation are essential to establishing screening as a routine part of medical care. Designing acceptable procedures depends on an informed awareness of the views of consumers that takes full account of the wide individual variation in attitudes and views.

(3) Is there a sub-group of patients who suffer adverse psychological consequences?

Numerous studies have found that presentation of risk information does not seem to be worrying to the majority of those screened; this is encouraging. However, clinical impressions and research that concentrates on mean scores within groups may well obscure rather important consequences for a minority of subjects. It remains possible, even probable, that sub-groups (especially of those screening positive) became more worried about their health and generally more anxious.

There is a clear analogy with what we know of emotional reactions to major physical illness; most patients are remarkably resilient, but a vulnerable minority suffer significant and persistent anxiety and depression. Those with current or past psychological problems and those with major life difficulties are especially likely to be vulnerable. The general conclusion that screening has few overall psychological consequences is important and reassuring, but it should not obscure the need to identify and treat those who do suffer problems. This study, like most other studies of screening, tells us nothing about this issue.

(4) What do measured changes in behaviour and beliefs mean in clinical practice?

A more psychologically informed view of the impact of screening, one which is both more comprehensive and more responsive

to individual variation, must have implications for the provision of services. These are of two types:

- Changes in the procedures to facilitate maximum effectiveness and fewer side effects for populations, and
- Flexibility to allow extra or different procedures for important sub-groups of subjects who have particular individual needs.

The second aim is likely to be the more difficult to incorporate into routine procedures for large numbers of people. It must depend on our identifying the nature of possible worries and problems, on simple assessment procedures and on our ability to provide flexible care. Success in persuading those who are reluctant to take part in screening, and in dealing with the anxieties of a minority and ensuring maximum effects on behaviour, will undoubtedly be key issues in the overall effectiveness of screening.

The BFHS study does not provide any definite answers, but it does indicate the need for further research to focus on the issues that it raises. It also suggests that those involved in screening would be well advised to think about the issue of maintaining enthusiasm for risk factor change, and it illustrates the importance of considering psychological impact in designing any screening intervention. Further research in relation to cardiovascular and all other screening should make the fullest use of established psychological methods and models. It should also be based on a comprehensive approach to individual variations in beliefs, vulnerability and behaviour.

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General practitioners and mentally ill people in the community: the GMSC's advice is over-defensive

THE General Medical Services Committee (GMSC) has recently issued guidance for GPs on their role in the assessment and continuing care of mentally disordered people in the community.[1] This followed the Department of Health's publication *Building Bridges*,[2] which outlined policies on inter-agency working, including the Care Programme Approach (CPA), whereby specialist teams conduct assessments, and institute and review care supervised by a key worker.

The GMSC guidance states that GPs are discharged of their responsibilities once they have assessed patients and identified a need to refer them elsewhere. Subsequently, they are obliged only to treat intercurrent illness unrelated to the mental condition, and to 'draw to the attention of those operating the service... patients' requests for help which indicate that risk has not adequately been assessed or supervised'. GPs should not be key workers because the CPA is intended to extend specialist supervision into the community. The legal basis of general practice, the guidance asserts, 'depends upon the wish of people to seek help', and 'the whole point of the CPA is to cover situations where patients cease to seek help'. GPs should not prescribe medication for the mental condition because, in doing so, they accept responsibility for monitoring treatment which they do not control. Patients who are violent, but are not detained under the Mental Health Act, may be removed from a doctor's list on the grounds that their violence appears not to be due to mental illness. The statement concludes with a call for increased funding to implement the CPA more widely.

This defensive stance reflects the difficulties experienced in obtaining specialist care in some areas, and real worries about personal safety. Applied literally, however, it would hinder efficient co-ordination of community services and is unlikely to improve patient care. It effectively gives GPs permission to wash their hands of people with severe mental illness (admittedly a difficult group). Would this less than professional response be countenanced for patients with intractable epilepsy, brittle diabetes or similar conditions, who, despite specialist supervision, often need their GP's help ?

The guidance ignores the realities of the current situation. GPs have been involved in the care of severe mental illness outside hospital ever since the early days of community care.[3,4] In the last 30 years, studies have consistently found that 25% to 40% of such patients have no contact with specialist services and rely on their GPs for medical care, including long-term psychotropic medication.[3,4,5,6,7] Some patients will only accept help from their GP, who may be known by patient and family for years. Where patients do not seek help themselves, requests for involvement may come from the family, friends or others. GP responsibility cannot end at the point of referral. The Ritchie Report on the care of Christopher Clunis clearly highlighted that safe practice with this difficult patient group requires that responsibility remain with the referrer until it is known that another professional has effectively accepted it and taken over.[8] It recommends that GPs should play a full and active part in the CPA for their patients.

The large majority of GPs do not wish to be key workers for these patients and prefer that the prime responsibility remain