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.

RICHARD MAYOU
Clinical Reader in Psychiatry, Department of Psychiatry, Warneford Hospital, Oxford

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Address for correspondence
Dr R Mayou, Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX.

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

with the psychiatrist. Nevertheless, they are prepared to share in their care.[9] If Community Mental Health Teams accepted continuing responsibility for all long-term mentally ill patients, their case loads would increase considerably, leaving them pre-occupied with routine follow-up and less able to respond promptly and adequately to help GPs with their most difficult and demanding patients.[10] The CPA should be applied to all patients accepted by the specialist. It is not just for the non-compliant. Specialist services are not, however, obliged to accept all referrals. Their involvement may be inappropriate for patients whose conditions are stable, who are compliant with treatment, and who prefer to consult their GP. Psychiatric teams have been instructed not to take on case loads so large that they can no longer function effectively,[2] and must, therefore, be able to discharge patients back to their GPs. Legal obligations to provide continuing care exist only for certain patients discharged from detention under the Mental Health Act.[2]

The GMSC has set up a task force to prepare more detailed guidance. It should consider how specialist services can be most efficiently targeted on those patients in greatest need. Increased resources must be provided, especially in the inner city areas where morbidity is highest[11] and increased mobility mitigates against developing good GP–patient relationships. GPs should not be key workers, since the CPA aims to ensure specialist supervision. GPs should not prescribe where they feel unqualified to monitor treatment, but could be encouraged to learn more about the care of mental illness. Severe mental illness is not a tidy concept and no simple definition exists. GPs and specialist services must evolve a mutual working understanding of their respective contributions to care in this area. This requires increased dialogue between primary and secondary care, not a unilateral declaration of limited responsibility.

TONY KENDRICK

Senior Lecturer in General Practice,
St George's Hospital Medical School

TOM BURNS

Professor of Community Psychiatry,
St George's Hospital Medical School

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Address for correspondence
Tony Kendrick, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE