base our clinical decisions on imperfect clinical evidence, basic sciences, and common sense.

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Primary care of patients with schizophrenia

Sir,

The policy paper by Burns and Kendrick (August *Journal*)[1] highlighted the need for mental health research in primary care, and I would wish to suggest some important priority areas.

Assessment. The Care Programme Approach (CPA) achieves multidisciplinary assessment for complex needs among patients receiving secondary care. In our experience of commissioning psychiatric care in Manchester, GPs wish to access thorough assessments of patients with chronic mental illness at periods of vulnerability, often not necessitating referral for psychiatric opinion.

In our own practice population of 13 000, 14 patients with chronic schizophrenia are not receiving CPA levels of care, and only receive medical perspectives on their condition via the GP, practice nurse, and occasional outpatient psychiatry assessments.

If GPs are to reflect improvements in management for patients with schizophrenia, they need access to other, non-medical disciplines working closely with them in practice.

In 1995, we introduced a mental health social work service into primary care,[2] which has opened up more primary care management options for patients with chronic severe, non-psychotic illness. We plan to extend the application of GPs' skills at the level of primary care management of psychosis. Primary care and preventive mental health promotion activities may be performed by different professionals, and liaison has certainly broadened our management options in primary care for all patients with chronic severe mental illness.

Often the important assessment for the GP is that of a patient's vulnerability and functioning at an early stage of deterioration. Many chaotic patients do find general practice accessible, although doctors find it increasingly difficult to assess patients who are not well known to them, who have complex needs, and who are often deluded even when well. The process of subsequent contextualization of any consultation, usually through telephone calls to carers and involved professionals, is time-consuming but informative in triggering further action.

This skill in acute assessment and crisis management by GPs, and the subsequent response of the secondary services, needs further research.

User views. There is a need for research into the perceptions of primary care provision for patients with schizophrenia, particularly in a climate where community residences are established with little discussion with local practices, which may not have the experience or skills required.

The importance of involving users in the design of future services is particularly relevant in encouraging compliance in schizophrenia. Some patients use the GP for limited activities, e.g. acquiring sick notes; others enjoy total general practice care. We need to respect issues of choice while acknowledging some variation in quality and availability across the sectors. This has implied training and resource consequences for primary care teams and for primary care-led purchasing of comprehensive mental health services. Furthermore, the increased empowerment of those patients best able to monitor their own therapy[3] may give rise to improvements in care. This trend for increased patient involvement is likely to be further assisted by the continued introduction of the newer antipsychotics, which are more acceptable to many treatment-resistant patients.

If users want GPs to undertake levels of care for schizophrenic patients, the quality of that care should be reflected and resourced to enable close working with our psychiatric colleagues. Practices must be better supported by other disciplines and resourced for training in the future. Our research programme should reflect these changes in the process of care of primary, secondary, and independent sectors, and should evaluate and engage the user prespective in any planning.[4]

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Provision of care for alcohol and drug misusers

Sir,

I enjoyed reading Deehan *et al*'s original paper (November *Journal*) examining GPs' attitudes towards providing care for alcohol and drug misusers.[1] I agree that this is an important area requiring further study.

The authors conclude by asking what can be done in real terms to encourage GPs to work with drug misusers. Perhaps the question, when so many GPs fail to respond to incentives to become involved, is where should this population of patients be cared for?

From personal experience, I found it impossible to meet the needs of my other patients while caring for members of this group, who present with great frequency and expect fast access. The nature of their problem requires a service configuration that is not found in most general practices. Additional resources for additional services, many of which are not within the power of primary care to deliver, need to be found.

ELEANOR GUTHRIE