continued re-assessment. Recording progress should be accurate and describe real activity rather than be summarized in relative, even meaningless, terms like 'fair'. [*Chapter IX, page 425.*]

At transition from school to 'adult' the future for some will reasonably be eventual placement in the community, perhaps successfully placed in either open or sheltered employment, and appropriately either with the family at home, in residential employment, or appropriate hostel care within the community, in all cases requiring continued expert support. [*Chapter IX, page 42.*]

For those adults in hospital the widest range of activity must be available, from the simplest to the most skilled. Training continues both in the work situation and through the encouragement of physical activities, and in music, dance, games, and social concourse. [*Chapter XI, pages 465-78.*]

In recent years there have been important developments variously described as 're-socialization' and 'community care' etc. Historically the attitudes towards the severely handicapped have evolved from the persecution or complete neglect of some centuries ago, first to the early attempts of training at about 1800 or so. [*Chapter XIII, page 488.*]

Later the first institutions were aimed at *cure*, but disappointment later led to an alarmist era when all social evils were deemed due to the presence of 'defectives' in the community, and the subsequent aim was to provide 'asylums', or 'colonies' for life-long care. [*Chapter XIII, page 489.*]

Eventually this aim was modified by the realization that even at their zenith of development the Institutions housed less than a third of the gravely handicapped, and but a fraction of the mildly mentally handicapped.

The realization that the vast majority of the mentally handicapped would always live within the community eventually focused scrutiny on to the need for developing community facilities. The change of social attitudes has not lessened the need for 'care' but extended our concept of what that care may be. One of the principal aims of hospital care is to fit the largest possible number of the handicapped to take their place in community life, leaving in hospital only those who cannot reasonably be cared for as well in any other way. Discharging a patient to the outside world with no reassurance of further care is inhumane. [*Chapter XIII, page 490.*]

Permanent segregation for all the mentally handicapped within institutions was never achieved, found to be impracticable, and realized to be undesirable on any account. Society now realizes its responsibility to provide, in the community, surroundings and occupations adapted to the needs of the severely mentally handicapped. [*Chapter XIII, page 491.*]

The outlook of staff in subnormality hospitals is widened, and the value of the hospital is increased by an appreciation of the development of community care. [*Chapter XIII, page 493.*]

The community, for its part, must provide the widest range of facilities, resources, and staff, so that the total pattern of care is adequate. [*Chapter XIII remainder.*]

Community Psychiatry

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My invited attendance at a College working party on community psychiatry has prompted this communication.

The working party has been examining the possibility of establishing training posts in this sub-specialty, but to date have failed to agree on a working definition of community psychiatry. The issue of whether community psychiatry should warrant a separate appointment or be seen as part of conventional consultant work also remains unresolved.

In Edinburgh, an unusual system of community psychiatry has evolved over the last eight years which, it is suggested, could offer an alternative approach to mental health care. It shows how the impetus for initiating shared community care of psychiatric disorders can come from the psychiatric services, and how working in the community can facilitate socio-medical and inter-agency approaches to psychiatric treatment.

Brown, Querido, Rutter and other researchers have convincingly shown that social and environmental factors play an important part in predisposing to, precipitating and perpetuating most psychiatric disorders, and that psychotherapy and drug treatment are insufficient to alter long-term morbidity and outcome of illness without taking these factors into consideration.

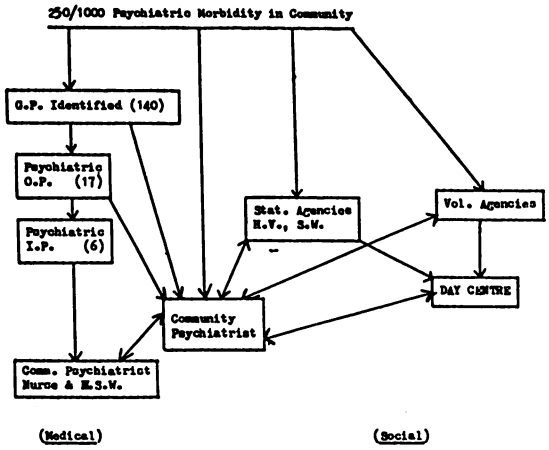
The WHO working party on 'Changing Patterns in Mental Health Care' (WHO, 1980, Euro Report 25) also observed that 'favourable results are being obtained by taking special account of the social aspects of mental illness', and concluded that 'services should be community based ... comprehensive ... with various agencies and services for each area effectively co-ordinated.'

Goldberg and Huxley, in their recent publication *Mental Illness in the Community*, show that the prevalence of psychiatric disorder in the general population is as high as 250 per 1,000, yet of these only 17 per 1,000 are referred to psychiatric out-patients and 6 per 1,000 admitted to psychiatric hospitals. In other words, the bulk of psychiatric

illness remains within the community neither identified nor treated by psychiatric services.

The Royal College of General Practitioners' working party on prevention has published an excellent report (No. 20) recommending amongst other things that GP training should incorporate knowledge about preventative epidemiological psychiatry and skills in counselling and group management, including involvement and statutory resources and self-help groups in the community. (For review, see *Bulletin*, August 1981, p. 150.)

These recommendations are remarkably similar to the current approach adopted to community psychiatry in Edinburgh. The psychiatrist operates in one sector of the city called Craigmillar, a large housing estate with over 25,000 inhabitants ranking high on all the defined indices of social and environmental disadvantage. The organization of services in this area of Edinburgh is represented in the diagram



which shows that the community psychiatrist provides an additional and complementary service rather than replacing existing staff. The community psychiatrist aims to reach psychiatric disorders not generally accessible to psychiatric services. The service does so by facilitating a communication, providing training and initiating shared care between a variety of primary care agencies; the preventive work done aims at social rather than medical intervention. The following is a brief description of the variety and scope of the work.

1. *Individual or relationship counselling in domiciliary setting*

Patients are referred informally from general practitioners, health visitors, social workers, voluntary community workers, or by self-referral with GPs usually informed shortly before or after the first interview. Prior agreement with most GPs has been obtained for this informal type of referral, which has the advantage that problems can be seen early. The good working knowledge of the area, and the frequent practice of domiciliary visiting allows a realistic assessment of psychiatric and social problems to be made and appropriate utilization of available community resources can be effected. This approach offers an opportunity for training both psychiatric and GP trainees in community management of minor psychiatric disorders and crises normally handled by GPs or self-poisoning units, but rarely available for teaching purposes in a psychiatric setting. It promotes the identification and understanding of problems experienced by GPs and other community workers and so facilitates mutual respect, training and support and clarifies the particular and relevant skills provided by each agency.

Most important, the community psychiatrist can use a sliding scale of action from psychotherapy to brief crisis intervention, or individual or family counselling, or can make a single assessment and arrange secondary follow-up and support by statutory or voluntary community workers who can deal with the social problems and report on progress over time.

2. *Interaction with statutory and voluntary agencies*

In addition to participating in shared care of patients, the community psychiatrist initiates regular visits to the local social work team, health visitors, community workers, schools, Women's Aid, Edinburgh Counselling Group, etc, potentiating the mutual exchange of ideas and offering opportunities for training and education and enhanced inter-agency communication. As a result, cross-referrals can occur more readily, with each agency clarifying its boundaries, responsibilities and resources yet at the same time more confidently risking blurring these boundaries and sharing responsibilities for individual cases. The community psychiatrist can mobilize medical supports or in-patient care through his or her links with the hospital services so that a good working relationship can be established between hospital and community (and vice versa), with the community psychiatrist where necessary acting as a confidentiality filter between medical and voluntary agencies.

3. *Preventive work*

Once accepted in the community, the community psychiatrist is able to promote health education in schools in social and psychosexual areas, working with teachers or pupils. Work with the local community group (Craigmillar Festival Society) has been useful in promoting local clubs, e.g. mother-and-toddler, youth, unemployed, elderly, etc, where the psychiatrist acts as a supporter and trainer for the workers who run the clubs. Through these interactions medical weight can be added to local pressure groups demanding change in such matters as housing policy, DHSS policy, social work priorities, etc. Multidisciplinary meetings of relevant workers have been organized to look at local

issues relating to such issues as teenage pregnancy, glue-sniffing and unemployment.

The psychiatrist is also one of an anonymous panel doing 'live' counselling over local radio, and lectures regularly to home-helps, social workers, etc, on aspects of mental health.

4. *Identification and facilitation of new services needed in the area*

A social day centre (open six days weekly) has been set up by a small multidisciplinary support group in Craigmillar, funded by the Mental Health Foundation on the basis of a proposal submitted by the community psychiatrist. This grant, together with additional funds from social work and psychiatric hospitals, finances the centre. This is run by non-professional workers (one with some counselling experience) with the background support of most of the primary care agencies. There is no formal registration of clients, and referrals are informally made or are by self-referral. The community psychiatrist maintains a close link with the workers and sees individual clients only by request. This allows a sliding scale of support from social club, or counselling, to psychiatric referral or hospital if needed. In the first six months over 75 clients have attended with an average attendance rate of approximately 15 per day, of which a third are ex-psychiatric patients, a third have alcohol problems, and a third have personality problems. Two-thirds of the clients are women with ages ranging from 20 to 65. In the first six months of operation this day centre has filled an important gap in the medico-social services in this deprived area. Many of the ex-patients have improved in their social skills and gained in self-confidence and (perhaps coincidentally) the admission rate of the hospital sector team has dropped. The annual cost of the centre is approximately £9,000.

From this short communication (a fuller account is being prepared) this approach to community psychiatry appears to meet some of the proposals put forward by the WHO working party, reaching the general practitioner range of psychiatric problems and also allowing the psychiatrist more opportunity to manipulate social change and share support with many other agencies unavailable to the hospital-based psychiatrist.

Several questions, however, are raised by such a role. Is it feasible to propose such an additional community psychiatric service reaching a new sector of psychiatric morbidity when conventional hospital-based staff are already over-stretched?

The author feels that, by careful redeployment of existing personnel and increased use of nurse therapists, both in hospital and in the community, such an approach need not add an extra financial or personnel burden to existing NHS services. If existing consultants and senior registrars could be encouraged to form more links in their own communities (a process enhanced in urban settings, especially if services are sectorized) then it could be argued that they would not only be more effective in their assessment, overall treatment and prevention of psychiatric disorders, but also in facilitating better communication and support between agencies, and in offering more appropriate psychiatric experiences for clinical trainees.

Does a community psychiatrist threaten the role of the psychiatric hospital social worker? From experience in Craigmillar, the responsibility of the hospital-based SW has evolved mainly in work with the ex-psychotic hospital population of in-patients and out-patients in conjunction with hospital staff and community psychiatric nurses. The community psychiatrist, on the other hand, takes those with psychiatric illness in the community as his target population, as in need of individual counselling and the support of a wide variety of caring agencies working with this group. The medical qualifications and autonomy of the community psychiatrist may help to provide more 'authority' for initiating new contacts and offering consultation services, etc, although the medical and psychiatric training of the psychiatrist is possibly no more appropriate for such work than a social science qualification.

The difference in the service offered by a short general practitioner consultation and a full psychiatric assessment needs serious question.

Could the Royal College of General Practitioners and the Royal College of Psychiatrists be encouraged to re-examine their roles both in treatment and in undergraduate, GP and psychiatric training for counselling psychiatric disorders, so that responsibilities can be more clearly delineated and shared, not only between professionals but with voluntary agencies too? In this way, a more efficient and ultimately cost-effective psychiatric service could be offered, supporting both those with major psychiatric illness and the larger population suffering from minor illness or seeking help in an emotional crisis.