columns

approximately one session per month (including committee meetings). You will report to the Director of International Affairs. Interviews will be held on the afternoon of Tuesday 2 October 2001.

If you are interested in applying, please contact Mrs Joanna Carroll, Postgraduate Educational Services Administrator (Overseas Liaison), Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG by 28 September 2001.

Vanessa Cameron Secretary, Royal College of Psychiatrists

Institutional Abuse of Older Adults

Council Report CR84 £5.00. 24 pp.

This report was prepared amid increasing concerns about the care of elderly patients in long-stay settings and newspaper criticism of doctors' attitudes to older people. Abuse is maltreatment as a single or repeated act or neglect; it may be intentional or due to ignorance or thoughtlessness, by a person or persons in a position of power. It covers five domains: physical, sexual, social, psychological and financial. It is underrecognised and underreported. Elder abuse takes many forms, ranging from subtle interactions to acts that are frankly criminal. What links the range of behaviours is that they occur in situations in which the victim is dehumanised. The abuser relates through power in the absence of clear thinking. Institutional abuse includes individual acts or omissions and managerial failings in which the regime of the institution itself may be abusive.

The subject of elder abuse has generated an increasing body of literature but little specifically about the role of doctors. This report aims to define the role of doctors in prevention, detection and management of abuse in institutions, to raise awareness, improve practice and to extend an understanding of a social, organisational and individual psychodynamic perspective to the aetiology and manifestation of abuse. Some abusive behaviour is consciously enacted. The majority is out of ignorance, unthinking and ageism, factors that can be addressed in training.

Doctors are in a position to influence significantly the culture and atmosphere of the units where they have patients. Old age psychiatrists have a responsibility to take the lead in prompting an examination of ageism and the capacity for abuse in the homes and wards where they work.

The report concludes with a list of recommendations for the organisation, the clinical setting and training. The recommendations are applicable to other vulnerable people in institutions.

J. Garner **S. Evans**

Community Care

Council Report CR86 £7.50. 64 pp.

This new Council Report replaces the College's previous position on community care, *Caring for a Community*, published in 1994 (CR36). Its aim is to summarise the College's views on the core components of humane and effective community care for adults of working age with mental illness. It reflects the significant changes in the UK context over that time – both the increasingly critical stand taken by some politicians and interest groups, and the welcome emphasis on clinical governance and evidence-based practice enshrined in the recent National Service Framework (NSF). This report has evolved alongside the NSF, and covers much of the same ground. Some of the terminology will have changed but we have retained terms (such as keyworker – instead of care coordinator) that were in current use during our deliberations. It does not deal with issues of training or workforce planning because these are considered elsewhere.

We have tried to strike a balance between being comprehensive and being focused. Colleagues have told us that they would like some concrete figures and proposals to work around, both to aim at and to use in local discussions. This has inevitably involved judgement and selectivity about the content. Not all these judgements can be supported by research findings but we have consulted widely. Despite the prescriptive style of some of these suggestions they in no way deny the importance of local circumstances or the need for local sensitivities and adjustments.

This is a clinically-led document. We believe that psychiatry, working closely with our partners (members of the wider multi-professional mental health team, social services and the users of the service and carers), should take an active lead in the continuing development of community services. We should neither back off from them nor adopt a reactive stand to externally driven policy.

Professor T Burns Working Group Chairman

Proposal for a Special Interest Group in Primary Mental Health Care

Procedure for establishing a special interest group:

(a) Any member wishing to establish a special interest group shall write to the Registrar with relevant details.
(b) The Registrar shall forward the application to Council.
(c) If Council approves the principle of establishing such a special interest group then it will direct the Registrar to place a notice in the *Bulletin*, or its equivalent, asking members of the College to write in support of such a group and expressing willingness to participate in its activities.
(d) If at least 120 members reply to this notice, then Council shall formally approve the establishment of the special interest group.

In accordance with this procedure, Council has approved the establishment of a Special Interest Group in Primary Mental Health Care.

Standards II and III of the *National Service Framework for Mental Health* state that people with common mental health problems should have their needs identified and assessed in primary care, with management occurring along locally agreed guidelines as far as possible either in primary care or with recourse to community resources, using NHS Direct and other care pathway management systems for guidance. Evidence suggests that there is a need for standardisation with regard to care pathways at the primary/secondary care interface. It is envisaged that a special interest group in this area could provide a forum for members of the College sympathetic to these issues to share ideas and experience in this area.

Joint meetings and conferences with the Royal College of General Practitioners could be organised as part of the process of consultation and liaison, and members of that College could be invited to join the group, once established.

Members are invited to write in support of this group and express willingness to participate in its activities. Interested members should write to Miss Sue Duncan at the College. If 120 members of the College reply to this notice, then Council shall formally approve the establishment of this special interest group.

Mike Shooter Registrar, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

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