members of the primary health care team at a community health centre (CHC) in Melbourne, Victoria, Australia.

Deer Park CHC, Melbourne, serves 18,000 people (with predominance of nuclear families, working-class families and a migrant population). The clinical staff of the centre comprises medical (eight full-time salaried GPs), nursing (two community nurses, two clinic nurses and one nursing aide) and paramedical (one clinical psychologist, one welfare officer, one craft supervisor and one physiotherapist). People of all ages and of both sexes attend the centre (3,000 contacts per month).

The psychiatric clinic was initiated by a senior psychiatrist from Footscray Psychiatric Hospital (the regional psychiatric hospital about 11 km from the centre). Initially, one session per week was provided but later changed to one session per fortnight. The main objectives of the clinic were:

(a) (i) to see the patients referred by the GPs or the clinical psychologist; feedback was provided through the written reports and face-to-face discussions
(ii) to follow-up the patients discharged from Footscray suffering from major psychiatric disorders who lived in the catchment area of the centre.

The new and difficult patients were initially followed-up by the consultant psychiatrist alone or jointly with the other team members, but every attempt was made to refer the patient back to the GP with backup support.

(b) to be available for consultation with members of the primary health care team.
(c) Other services provided were:
(i) Review meetings once in 4 to 6 weeks to meet the GPs and other members of the primary care team to review cases and discuss difficult management problems.
(ii) Availability of the consultant psychiatrist at the 'base' hospital to discuss management problems on the phone and/or provide early/immediate assessment/intervention to prevent admission at times.

Thus, GPs and other team members of the primary health care team at the centre were managing not only their usual cases with minor psychiatric disorders but also patients with major psychiatric disorders. The community nurses maintained close contact with the patients and their families through regular home visits or contacts at the centre providing support and also monitoring patients' medication.

The evaluation of the liaison service using a simple questionnaire revealed:

(a) Advantages to the primary care giver: better understanding of the psychiatric disorders, especially psychotic disorders; better understanding of treatment procedures, especially psychotropics; improved confidence and ability to cope with patients particularly psychotics; better relationship with the patient; backup support from psychiatrist.
(b) Advantages to the patient: more comfortable about the environment of the centre; close proximity to home and reduction in travelling; better co-ordination of care; less stigma.
(c) Advantages to the family: convenience because of close proximity; easy availability of the psychiatrist; improved relationship by better communication.

In conclusion, combination of different psychiatric 'liaison-attachment' schemes (Mitchell, 1989) employed at a primary health care setting appeared to be quite effective and useful placing a lot of emphasis on face-to-face contacts and discussions between the psychiatrist and primary health caregivers.

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Family psychiatry and family therapy

DEAR SIRS

In Hugh Freeman's 'conversation with John Howells' (*Psychiatric Bulletin*, September 1990, **14**, 513–521), comment was made on the differences between family psychiatry and family therapy.

I don't know where he got his ideas on family therapy from, but they are certainly not what any family therapists nowadays would say about themselves. In fact, all the things that John Howells was saying about family psychiatry are precisely things that family therapists would claim. The only difference may be that family therapy works with all kinds of family, not just those with a "sick" member.

Family therapy views a family as a "system", or in John Howells' words, "a total situation" to which the family therapist also hopes to be able to bring about harmony, and a return to normality for the whole group. Perhaps more than in family psychiatry, family therapists might look at the function of the "sick" label or role and expect to replace this in due course with other ways of understanding the group.

If family therapy and family psychiatry are so similar, perhaps we should join forces rather than

work away on the incorrect assumption that we are so different.

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DEAR SIRS

In the interview with Dr John Howells (*Psychiatric Bulletin*, September 1990, **14**, 513–521) Howells states that in family psychiatry "the principle is that an individual who becomes sick is an element in a sick family". In contrast he says that in conjoint family therapy "the principle is to use the family to get the identified patient well". He seems to be indicating therefore that family therapy is a technique for helping individuals get better.

I would respectively point out that this is a gross misunderstanding of family therapy. The essence of family therapy is that the conceptual focus is on the whole family system, and that individual behaviour is seen as arising from, and feeding back into the family system. Treatment is aimed at altering the whole system for the benefit of all members. The vast majority of family therapy literature in the last 20 years has emphasised these very points, which Howells seems to be claiming to belong specifically to family psychiatry.

It seems to me that there is really no difference between family psychiatry and family therapy in terms of the conceptual focus or the unit of intervention.

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DEAR SIRS

I can understand the reason for Dr Child's and Dr Lask's bewilderment. The first key lies in Dr Lask's phrase "family therapy literature in the last 20 years". There was a whole generation of literature in the UK prior to 1970 and virtually the whole of this was on family psychiatry (Chadwick, 1971). When I gave my Chairman's address to the Child Psychiatry Section in 1961 'The Nuclear Family as the Functional Unit in Psychiatry' (Howells, 1962), I defined family psychiatry as a clinical approach which took the family as the functional unit in clinical practice. This definition was elaborated in my 1963 book *Family Psychiatry* describing my ten years of work 1950–1960. Post 1970 came the influence of the American conjoint family therapy literature, begun originally by my old friend Nathan Ackerman; as I said, this movement used a family group to help an individual patient. The family systems approach of family psychiatry cross-fertilised conjoint family therapy and 'family therapy' was a term commonly adopted for that movement subsequently. So far so good.

In my interview there was insufficient time to point to still major differences between family psychiatry and family therapy. Firstly, family psychiatry is a term which denotes a way for the profession of psychiatrists to practise psychiatry with the family as patient. It aims to give the same level of care to the mental patient as any other patient. Thus a highly trained practitioner, a consultant, takes direct responsibility for the patient; it eschews the unethical practice of 'covering'. Secondly, it is concerned with family pathology (not other family anomalies). Thirdly, it is a wide psychiatric approach concerned with the theory of psychiatry, clinical organisation, experiential psycho-pathology, multi-dimensional structured family diagnosis and multiple family treatment procedures (including vector therapy). Family therapy concerned, as its title suggests, with therapy and the treatment of families in groups is only one of family psychiatry's general procedures, and only one of its treatment procedures. As Rubinstein (1977), an American family therapist, commented "the field of family therapy is to be considered a branch of the broader discipline of family psychiatry".

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Membership of women psychiatrists' support groups

DEAR SIRS

The article 'A support group for women psychiatrists' (*Psychiatric Bulletin*, September 1990, **14**, 531–533) raises some interesting points. As a former trainee on the Royal Free rotation and one of the "new women" who were not invited to join the group, I am also aware of the impact this experience had upon us.

It was particularly difficult to be informed about the group and invited to a meeting, only to have it made clear later that we were not being asked to join, but merely to observe and perhaps to learn. In

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