group. Given proper encouragement by competent staff we would contend that such an arrangement can even be beneficial to both classes of patients. Surely also the fact that this group is so small and so vulnerable should preclude us from abrogating our responsibilities to them.

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Network community mental health care

DEAR SIRS

I find the ironies contained in Dr Peet's paper describing a 'network community mental health care' system (*Bulletin*, October 1986, **10**, 262–265) both amusing and dismaying. I spent two years in Canada (1983–4) as the Medical Director of a community and outpatient psychiatry service which had previously been run along exactly the lines described by Dr Peet. Network liaisons had been developed (one social worker spent almost all his time working out and supervising these liaisons, all clinic workers attended regular meetings with one or more social agencies), referrals were accepted by the whole team (two nurses spent almost all their time taking these referrals but not seeing the clients, 'intake meetings' were held to allocate key workers depending on the needs). 'Clients' were seen either in the Department or at their community base, or a discussion about them was held with the referral agency in order to help the agency deal with the problem; various indirect services had been set up. This community psychiatry service had been running for several years and was widely regarded as almost useless. I was asked to reorganise the system, which I did by introducing assessment and management meetings, doing away with the intake system, reducing the time spent 'servicing community liaisons' and increasing the time spent with patients. Since I was often asked what 'model' I was using, I called it the 'assessment and management model', though to myself I thought of it as the 'proper psychiatric practice model'.

I therefore find it frightening that exactly the sort of system which North America has been giving up in the last few years is being promoted so enthusiastically here. Dr Peet (whom I note has since moved on from the service he describes) starts his report by referring to the standard US Community Psychiatry Text[1], which he says indicates that the community mental health movement remains an important force in American psychiatry. I should like to quote from that book: "The bandwagon nature of community mental health, which dominated the field in the late 1960s, has long since past"—but not in the UK, we are just starting. Also: "Community mental health programs are in a state of crisis" and "uncertainty and even malaise hover over the field" and "the popularity of community-based services is rapidly deteriorating". (This last by Gerald Caplan himself) – again, not in the UK; we are undergoing unprecedented approval (at Governmental level) of the notion of community mental health and preventive psychiatry. It seems clear that we are now where the US was 10 or 20 years ago, except that we had, until the recent changes, a far better psychiatric service than the US did before their upheaval. I think that their upheaval was a genuine attempt to improve upon the appalling state of psychiatric service for the majority of US citizens. I think that ours is an NHS cost-cutting exercise backed-up by the enthusiastically anti-medical approach of many members of the multidisciplinary team.

No doubt I am swimming against the British tide at present – of course, as the tide comes in over here it goes out along the Eastern US coast! However, I sincerely hope that we can salvage what is left of our many worthwhile psychiatric institutions before they are swept away, leaving our patients drowning in a sea of professional net-workers but amateur psychiatrists. I also hope that Dr Peet's service will not be seen as a blueprint for others, who, unlike Dr Peet, already have good well-thought out services and units and who deal with areas which do not consist almost entirely of the young and middle-aged, rural middle classes.

J. M. BIRD

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REFERENCE

SCHULBERG, H. C. & KILLILEA, (eds.) (1982) *The Modern Practice of Community Mental Health*. San Francisco: Jossey-Bass.

DEAR SIRS

I read with interest Dr Peet's article describing a model of community psychiatry (*Bulletin* October 1986, **10**, 262–265). In my quest for a consultant post I have visited a number of districts, the last of which had adopted an unadulterated community approach that has deserved the unanimous applause of the national press recently, and I thought that I would share with your readership some of my experiences.

During my visit I met a number of people and, going with the times, the general manager featured prominently on my list and it is my meeting with him that I think is most interesting. He outlined to me the nature of community services in the district and his complete opposition to any form of institutional care, which I was later told included hostels. He later expressed to me his views on the functioning of multidisciplinary teams which, in short, was that the team leader could be anyone who happens to "show leadership qualities" and as far as he was concerned the psychiatrist was just another mental health worker.

However, the best of it was still to come when he started asking me my opinions about ECT, which rather took me by surprise as this was not a topic I expected to be discussing with a hospital manager. Here is an example of a Griffiths-type manager who happens to hold strong ideological views regarding mental health policy who has found himself in a position of power to push them through independently of

any empirical evidence. Moreover, he has not even shied away from letting his views be known about such clinical matters as ECT, a view which is inevitably ideological as he is neither a clinician nor a scientist.

It is interesting that Dr Peet mentions 'deskilling' as one of the ways psychiatrists might deal with their role in community multidisciplinary teams. I had not heard this term in this context until my visit to the above district but during the course of one day I found it had become an established part of my vocabulary.

The new management structure seems to have provided a vehicle that can be used by certain managers who happen to hold strong views on mental health to promote anti-psychiatry views and to encourage the 'deskilling' of psychiatrists. I think that this could represent a serious challenge to psychiatry and, judging by recent newspaper articles, psychiatrists' views do not seem to be much in evidence.

RIADH T. ABED

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Dr Vidya Sagar Kaushalya Devi Memorial Trust

DEAR SIRS

Dr Vidya Sagar was an eminent Indian psychiatrist, who trained at the Institute of Psychiatry, London, (1948–51) and dedicated his whole life to the care and attention of the mentally ill. He worked at first at the Mental Hospital, Amritsar and later on at Medical College, Rohtak.

His family, friends, relatives, colleagues and students have set up a charitable trust: Dr Vidya Sagar Kaushalya Devi Memorial Trust. The aims of the trust are to set up a Health Centre dedicated to carry out his ideals. The trust has received moral and physical support from a wide spectrum. The government of India has given four acres of valuable land in the centre of New Delhi. The Delhi corporation has promised financial support towards construction work. The Health Centre has the possibility of being a premier centre for psychiatric education and research.

Indian psychiatry has enjoyed a close and cordial relationship with its British counterpart. Most Indian psychiatrists have worked and trained in this country or North America. Teaching and training programmes at various academic centres in India have received extensive help and guidance from academic organisations in the United Kingdom, in particular the Institute of Psychiatry. We hope that with the Vidya Sargar Health Centre we will receive similar support not only from psychiatrists of Indian origin working outside India, but also from friends and well wishers all over the world. This is a worthy cause which requires urgent support. Financial donations should be made out to Vidya Sargar and crossed Account Payee Only. Offers of any other form of help should be conveyed to one of us (RG).

RAGHU GAIND

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Psychiatry and its stigma

DEAR SIRS

Regarding Dr G. E. Vincenti's letter, (*Bulletin*, September 1986, **10**, 249), based on my 44 years experience in seven different countries, may I suggest we review our trade name? I do not think that psychiatry or psychiatrist will ever be rehabilitated. Would not it be better to introduce *more widely* 'psychosomatic medicine' and 'psychophysician', just the same as 'neuro-physicians'? After all, is there any doubt that we are physicians and that we should be more so?

IMRE ZADOR

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ECT in the Netherlands and Britain

DEAR SIRS

Dr Kraemer's suggestion (*Bulletin*, October 1986, **10**, 280–281) that comparison between the Netherlands and Britain in the use of convulsive therapy could be used to examine the prevalence of manic-depression and psychoses for which ECT is used in the two countries. I would suggest that it could also be used to measure standards of treatment.

The only times I have ever seen extreme symptoms of agitation: running backwards and forwards, wringing of the hands, continuous moaning and pulling at the face and hair, was in two mental hospitals which did not use ECT.

MAX HAMILTON

Emeritus Professor of Psychiatry
University of Leeds

History of Psychiatry

At a meeting of the College at Robinson College, Cambridge on Friday 12 September, it was decided to seek permission from Council to found a Group for the Study of the History of Psychiatry.

The following officers were proposed: Chairman: Dr Henry R. Rollin; Secretary: Dr German Berrios; Members of Committee: Professor Sydney Brandon, Professor Rachel Rosser, Dr J. Jones, Dr David Healy and Dr William Parry-Jones.