communication is appropriate, to contact GPs by telephone. Our intention is to assess whether this will lead to an improvement in communication.

ACKNOWLEDGEMENTS

We would like to thank Dr Chris Barker for his helpful advice about developing the questionnaire and about the statistical analysis and those general practitioners who generously gave their time during the preparation for this study.

REFERENCES

[1]LONG, A. & ATKINS, J. B. (1974) Communications between general practitioners and consultants. *British Medical Journal, iv:* 456–459.

[2]MARGO, J. L. (1982) Letters from psychiatrists to general practitioners *Bulletin of the Royal College of Psychiatrists*, **6**, 139–141.

[3]BADO, W. & WILLIAMS, C. J. (1984) Usefulness of letters from hospitals to general practitioners. *British Medical Journal*, **288**, 1813–1814.

[4]PULLEN, I. M. & YELLOWLEES, A. J. (1985) Is communication improving between general practitioners and psychiatrists? *British Medical Journal*, **290**, 31–33.

[5]ANONYMOUS (1973) The hospital letter, (Editorial) *Lancet, i*, 245–6.

Working in Partnership. Lunch-time Meetings in Secondary Schools

JENNIFER A. HAYTER, Locum Consultant Psychiatrist, Department of Child and Family Psychiatry, Canterbury, Kent

In their major piece of research, *'Fifteen Thousand Hours. Secondary Schools and their Effects on Children'*,[1] Rutter and his colleagues showed how, with the right ethos, secondary schools could be a powerful force, promoting good outcomes over a range of measures, including attendance, exam results, behaviour in school and delinquency outside it.

Inspired by this, we, at the Canterbury Department of Child and Family Psychiatry, set about the task of exploring our interface with education, to determine how we might help to mobilise the therapeutic potential of local secondary schools for children in difficulties.

Our regular clinic meetings with the Canterbury educational psychologist to discuss the problems of children of mutual concern had already proved constructive. I had also happily participated for several years in in-service training courses for interested teachers, focusing particularly on 'Why children develop conduct disorder' and 'Psychiatric aspects of children with learning difficulties'. I had found teachers eager to understand why so many children foundered and anxious to learn how best to help. These contacts had already shown me how teachers often felt unsupported when trying to contain the problems of children with severe learning and behaviour problems. Often they struggled alone for too long, and when referral to us or to the School Psychological Service was made, there was a family in crisis, often alienated from the school. In the clinic too, we had long been aware that there were many more children in emotional difficulty than we were able to reach through the service we offered to children and their families.

So the challenge was to find a way to rally schools to be more effective therapeutic environments for children in difficulties; to help them to use child psychiatry and educational psychology efficiently by referring children at a stage when intervention had a better chance of success, and to work with us on therapeutic programmes, based on a clear identification of a particular child's needs.

Four years ago we set up a pilot scheme whereby we offered regular lunch-time meetings in secondary schools, once or twice a term, between myself as child psychiatrist, together with a clinic social worker from the Canterbury Department of Child and Family Psychiatry, the educational psychologist from the Canterbury School Psychological Service, and teaching staff concerned with pastoral care, as selected by the schools. We offered to discuss their problem children and to explore the interfaces between us, with the aim of working together more effectively to help the children in our care. This offer was taken up by four schools; in the past two years two more schools have joined the scheme.

We knew at the outset that for the meetings to be welcomed constructively, they had to detract as little as possible from the normal working commitments of the professionals concerned. We decided therefore to meet with our teaching colleagues over a working lunch, for one to one and a half hours. We hoped eating together would create an atmosphere of goodwill and help to break down inter-professional barriers. The arrangements varied from school to school. In some we ate in a room set aside for the meeting, where pupils helped to set the tables and deliver the food. In other schools we lined up in the school cafeteria with staff and pupils. This gave us an insight into the atmosphere of the school, and pupils saw us as an accepted part of an ordinary school day.

We learned that to keep a positive momentum the meetings had to be well organised in advance. Lists were exchanged of pupils put forward for discussion so that notes and relevant staff were available, and time was not wasted on half-remembered anecdotes. Schools found it

better to restrict staff to those concerned with the children under discussion, so that everyone felt involved.

In our discussions, medical confidentiality was strictly adhered to. If we sought to share out insights into the difficulties of children attending the clinic, we did this only with the permission of the parents. Most parents actively welcomed this liaison.

Our early work consisted mainly in clarifying areas of confusion about our respective roles and breaking down prejudices, myths and stereotypes which had often impeded efficient co-operation in the past. The issue of medical confidentiality was poorly understood by the schools, who had often seen it as an obstructive attempt to maintain an elitist professional distance.

We met with considerable confusion about the differences between the School Psychological Service and the Department of Child and Family Psychiatry, and what kinds of needs were best met by each department. At our meetings, children with learning problems and a variety of emotional and behavioural difficulties were discussed, and teachers saw at first hand our differing areas of involvement as well as problems in which both departments had a useful contribution to make.

We found some schools had been reluctant to approach child psychiatry in the past for fear of imposing a psychiatric label on a child. This had prevented many children being referred at a stage when clinic intervention would have had a good chance of success. Instead, we had been regarded as a 'last resort' agency, alerted only when suspension seemed inevitable, when angry feelings in all concerned had become so entrenched that constructive clinical involvement was difficult.

We tried to promote a more positive image for child psychiatry, showing how crises could be avoided by intervening at the right moment, pressing for earlier referrals where appropriate and encouraging schools to have realistic expectations of us and to know our limitations. We worked to 'de-mystify' the psychiatric approach. This became much easier with face-to-face contact, where the schools could see that we were talking about commonsense issues, and that we had constructive ideas to help with the children in their care.

By discussing the problems of individual children, we aimed to help teachers recognise that there could be many factors underlying problem behaviour, and that trying to control maladaptive behaviour without looking at these factors could be analogous to treating a troublesome symptom without seeking to identify and cure the underlying disease.

We found the meetings a useful vehicle for rationalising the approach to children with conduct disorder, many of whom also had learning difficulties. Studies showed that conduct disorder could arise as a result of learning problems and educational failure,[2,3] with the evident demoralisation and loss of self-esteem that this entailed. The implication was that effective remedial teaching for specific learning difficulties could reduce the incidence of some forms of conduct disorder in schools. The educational psychologist at our meetings identified specific learning difficulties, and advised on remedial approaches. Together, we emphasised the need to help the child with demoralisation caused by years of failure. The social worker counselled the parents. Where necessary, a full psychiatric assessment in the clinic pinpointed other aetiological factors. By encouraging earlier referral of children with conduct disorders, it became easier to improve parental management where the disciplinary style had been ineffective. At the same time we advised the school on a behaviour modification approach to the child, and the combined approaches complemented one another. We referred on to an adolescent day or in-patient unit, where appropriate. Thus, together we aimed to identify the root causes of a conduct disorder, and to explore all remedial and therapeutic avenues. When these failed to resolve a problem, a real need for residential schooling was more confidently advised.

Schools have traditionally been ready to refer disruptive pupils. We encouraged them also to look at their anxious, withdrawn, depressed and under-achieving pupils, and to explore ways of giving them more support. We were particularly impressed by the schools which had developed a support unit to which a vulnerable child could be withdrawn if necessary, while we helped the child and his family to resolve their difficulties, without resort to suspension or transfer to an adolescent unit. We found support units a very helpful stepping-stone when rehabilitating an acutely school-phobic child. In general, we found that the better organised the pastoral care system within the school, and the better the channels of communication between pastoral care staff and the staff who taught the child, the better were we able to complement the system and rally real support for the child.

We recently sought comments from the schools on the value of our meetings. They appreciated our support, and the recognition that teachers deal with disturbed pupils in schools. The face-to-face contact had enabled them to refer with more confidence, since they understand how we worked, which problems were serious, and at what stage a child needed referral. Understanding better the nature of the children's difficulties enabled them to focus their support more appropriately. One Deputy Head commented that our meetings had kept the pastoral care system within the school well organised by providing a regular focus on children in difficulties, ensuring that their progress had been monitored regularly. Junior teachers became more ready to report problem children to their seniors, without fearing their own competence might be questioned thereby.

From the clinic point of view, the schools' referrals to us became more appropriate, referred more often at a remediable stage, and much less often referred in crisis. Our biggest gain was that now we had obtained the trust of those schools, we could ask them to work in partnership with us, co-operating with our therapeutic programmes for individual children.

Thus, we established a forum at which members of three

different organisations,—the Department of Child and Family Psychiatry, the School Psychological Service and a Selection of Secondary Schools—operating within often very different conceptual frameworks, could come together and focus on common problems from their different viewpoints. This helped us to identify some of the gaps in the local services which were limiting the provision of an efficient system of support for children in difficulties. Where learning problems are part of the picture, an accurate psychological diagnosis is an essential preliminary to effective remedial help; yet many of these children would never be seen because of the inordinately large work load of the educational psychologists. This bottleneck effectively prevented the size of the problem ever becoming apparent. Where the learning problems were identified, there was a serious shortfall of remedial teachers able to offer specific help. Time after time we saw these children developing serious emotional difficulties, attributable at least in part to their learning problems. We would welcome more local educational provision, in the form of a tutorial unit for example, to which children could be withdrawn for specific help, but with the clear aim of re-integrating them into their normal schools later. Alternatively, could support units within schools take over this function, with specialist teachers trained specifically to help children with emotional and learning problems, and with a clearly defined input from the specialist support systems of educational psychology, child psychiatry, social work and the school medical service?

In this way perhaps we can realise more fully our aim of providing support to the schools, so that they can help themselves to become more therapeutically effective for troubled children.

ACKNOWLEDGEMENTS

My grateful thanks are due to Robert Collman, Educational Psychologist, Pamela Roberts, Senior Social Worker and our teaching colleagues who have participated in the meetings.

REFERENCES

[1] RUTTER, M., MAUGHAM, B., MORTIMORE, P. & OUSTON, J. (1979) *Fifteen Thousand Hours; Secondary Schools and their Effects on Children*. London: Open Books.

[2] ——, —, TIZARD, J. & WHITMORE, K. (eds) (1970) *Education, Health and Behaviour*. London: Longman.

[3] VARLAAM, A. (1974) Educational attainment and behaviour at school. *Greater London Council Intelligence Quarterly*, no. 29, 29–37.

Ex-phobic Volunteers in the Treatment of Agoraphobic Patients

PETER TYRER, Consultant Psychiatrist, Mapperley Hospital, Nottingham

Although behaviour therapy, primarily in the form of gradual and prolonged exposure to phobic situations, is now well established as the treatment of choice in most cases of agoraphobia[1,2] not all suitable patients receive this treatment. This is partly because behaviour therapy is time-consuming and, although there have been great gains made in recent years with the establishment of training for nurses in behaviour therapy,[3] in many peripheral hospitals few nurses have the necessary training. There are increasing demands made upon the time of the community psychiatric nurse and it seems likely that the proportion spent in behaviour therapy will be squeezed to a level that will deprive some patients of its benefits.

We therefore need alternative ways of delivering this treatment to those in need. In the course of developing psychiatric clinics in general practice[4,5] it was noticed that many phobic patients attended who had not been seen by the psychiatric services before. This was mainly because the clinics were nearer their homes and they felt less anxious about attending a general practice than a hospital clinic. It was also realised that there was no possibility of treating all these patients with existing nursing and psychological resources. As several patients who had been successfully treated by behaviour therapy expressed an interest in helping others with similar problems we felt it reasonable to explore the use of this 'hidden resource' in the treatment of new phobic patients.

The new behaviour therapists

All out-patients with phobic disorders referred from the north and east of Nottingham over a two year period were considered if their primary disorder was that of agoraphobia and they agreed to be seen by a volunteer therapist. All patients maintained contact with the referring psychiatrist during treatment although this was infrequent with no direct supervision of the volunteers. In addition the therapists saw some patients with phobic symptoms for advice on coping with them but did not get formally involved with therapy unless the primary diagnosis was that of a phobic disorder.

Thirty-four patients were seen in the course of the two years and 16 received a full programme of home-based graded exposure derived from established procedures.[6] Of the remaining 18, 10 were seen on one occasion only for advice, five received treatment but their therapists did not complete a full set of questionnaires, two dropped out of treatment within the first month and one was seen by a therapist without any formal psychiatric involvement.

Assessments were made with the Fear Questionnaire of Marks & Mathews.[7] The questionnaires were given to each patient before treatment and after four weeks and 10 weeks. The volunteers were asked to see their clients on approximately 10 occasions during this period but the frequency of contact was left flexible.