

# Historical applications of the Goldberg and Huxley *Pathway to Psychiatric Care Model*

John Hall\*

**Abstract:** The Pathway to Psychiatric care Model was published by David Goldberg and Peter Huxley in 1980, based on practice within the British NHS from 1948, and on epidemiological data mostly from Europe and the USA. The ‘filters’ in the model were derived from assumptions about practice, and levels of care, at that period. This paper explores the implications of applying the model historically to patterns of English psychiatric care firstly from 1834/1845 to 1959, with parallel public, philanthropic and private systems of healthcare; and secondly to patterns of care after c.2000. The model is a powerful conceptual tool for understanding how mental health systems function, and the central importance of referral and transition decisions. This analysis points to the influence of changing ‘regulatory cultures’, at one remove from the immediate clinical encounter, and to the implications of a much wider range of mental health practitioners than in 1980.

**Keywords:** Goldberg & Huxley pathway to care model; mental health care transition decisions; history of British mental health systems .

\*Address for correspondence: joni\_hall@btinternet.com

**Date accepted:** 24th January 2024

**Date of first (online) publication:** 11th April 2024

**John Hall** is Visiting Professor of Mental Health, Oxford Brookes University, and formerly Professor of Mental Health, Oxford Brookes University. He is a clinical psychologist by background, and for the past twenty years he has researched in the broad field of histories of mental health services and practitioners. ORCID 0009-0005-6547-7920

## **Introduction to the Goldberg & Huxley Pathway to Psychiatric care Model**

In 1980 David Goldberg, then professor of psychiatry at Manchester University, and Peter Huxley, lecturer in psychiatric social work there, published *Mental Illness in the Community: The Pathway to Psychiatric Care*. The book was immediately recognised as a key text in the then still developing field of psychiatric epidemiology. The foreword, by the leading psychiatric epidemiologist Michael Shepherd, pointed out that psychiatrists had based their concepts of mental illness on the highly selected sample of patients referred to them, so neglecting the large group of so-called minor psychiatric disorders which are centre-stage of the primary healthcare team. The book is a clarion call for attention to be paid to the detection and management of the forms of mental illness in the community who are not seen by psychiatrists.

The book pays detailed attention to the statistics on levels of mental illness in the community, mostly by reference to European studies. Many of those projects included challenges in trying to ensure that the transitions from one service to another met the needs of individuals, and that they did not fall into black holes between services. Understanding how people moved from one service to another, and creating sustainable care pathways between the established and the new mandatory services, was a major element of a number of these projects (Hall, 2005), and it was in that context that I first found the 1980 Goldberg and Huxley Pathway to Psychiatric care Model helpful. The model has been highly influential and is widely quoted in the literature on psychiatric community care and on what used to be termed *psychiatry in general practice*, now better termed *primary care mental health* (Gask et al., 2018b).

The model was of course focused on practice within the British National Health Service (NHS) administrative structures and systems that had been set up in 1948, and on epidemiological and other data collected mostly in the 1970s and mostly in Western Europe and the USA. The NHS had separated general practitioner (GP) services organisationally from specialist secondary care services, so that within any locality GPs were independent contractors, organised initially within local Executive Committees, and specialist secondary services were managed by local Hospital Management Committees (HMCs), with mental hospitals typically managed by their own HMC within a framework of NHS regions. So quite apart from clinical considerations, primary care physicians – GPs – were managed and funded through different agencies from psychiatrists, with their own priorities.

Implicit in the original pathways model were the assumptions underpinning that 1948 NHS system of medical care:

- Universal availability of medical primary care by a GP, free to the patient at the point of delivery

- Universal availability of secondary psychiatric care accessed through a psychiatrist, free to the patient
- Assumption of levels of medical competence, and public and political confidence in that competence, which permitted decisions made by doctors to be accepted without further checks
- Assumptions about the ability of doctors to agree on what constituted a psychiatric ‘case’
- Regulation of practice by the 1959 Mental Health Act, which was implemented in 1960

## **Modifying and extending the model**

One of my interests in the model was how it could be modified and developed from the original version. The original pathway to care model was structured around a framework of five levels of care, with transitions between each level mediated by a ‘filter’, so there were four filters in the model, each with their own associated characteristics, linked to the individual who made each key decision to move a person from one level to another. The four filters were:

- Illness behaviour of the person in the community – the putative patient
- Detection of psychiatric disorder - by a primary care physician
- Referral to a psychiatrist - by a primary care physician
- Admission to a ‘psychiatric bed’- by a psychiatrist

Linked to each filter are a number of factors ‘operating on each key individual’. For example, the three factors operating on the patient at the first filter are seen as the severity and type of symptoms, the level of psychosocial stress, and learned patterns of illness behaviour on key individual. The two factors operating on the psychiatrist at the fourth filter are the availability of beds, and the availability of adequate community psychiatric service.

This core pathway model can be developed in a number of ways. The model as at first conceived was uni-directional, in the sense that it addressed the filters which operate as an individual moves *from* the community to primary care and successively enters levels of care for more severe levels of disorder. It did *not* address the ‘reverse’ filters controlling how individuals move back to levels of care for lower levels of distress, as they are in conventional medical terminology discharged from either out-patient or in-patient care.

Another way to develop the model is to develop a fifth filter, internal to the psychiatrist-controlled mental hospitals, characterised by transfer to long-term

care. My own clinical and academic interests, from the time of my involvement in a research project at Leeds University (Hall et al., 1977), have continued to be with long-term serious mental health conditions. Not surprisingly, the ways in which this group were identified and treated historically are of interest to me. From the classic study of Tooth and Brooke (1961), predicting the likely reduction in the number of psychiatric beds needed in Britain, it was noted that after a period of admission of two years, the probability of discharge dropped significantly. A two-year length of stay then became the conventional cut-off between acute and medium stay in-patients, and long stay or 'chronic' in-patients, the great majority of whom had been given a diagnosis of schizophrenia.

The filter for that level of care is the decision by an acute care psychiatrist to either transfer to long-term care (to what were commonly called the 'back-wards') or to return to community care, with the factors including, for example, the patient's non-response to initial treatment. So such a fifth filter could be created:

- Level: long-term unresponsive psychiatric inpatient
- Filter: transfer to a long-term psychiatric bed – by a psychiatrist
- Factors acting on key individual - patient's non-response to initial treatment, and lack of other positive treatment or management options.

When 'deinstitutionalisation' began from the late 1950s, this distinction became of enormous significance. It was the less disabled and better functioning long-stay patients who were discharged first, so the related reverse filter was a decision by a psychiatrist to return such patients to lower-level of care. As the new tranquilising drugs meant that people in an acute psychotic episode could be maintained more easily in the community (often with the support of a community psychiatric nurse), it modified the factors affecting both filter four, potentially leading to admission, and this proposed filter five, now with additional options for community care.

## **Applying the model historically**

My second area of interest in the model has been to explore its use historically, both applying it to the period before the 1970s, and after c.2000. I have had a long-standing interest in the histories of mental health care, and research in the broad field of the history of mental health and psychiatry in Britain has been dominated by ideas formulated, and practices directed, by successive generations of mad-doctors, alienists, and psychiatrists. Until around 30 years ago much of the history was also written by them, until the advent of medical historians such

as Roy Porter and Andrew Scull. These histories have unsurprisingly privileged the role of psychiatrists, and have minimised the role of other health-care practitioners. The first history of mental health nursing in Britain, by Peter Nolan, was only published in 1993, and the first full history of occupational therapy by Ann Wilcock did not appear until 2002.

It then becomes significant that the second and third filters in the model relate to decisions made by primary care physicians – GPs. From a historical perspective, an interesting question is to ascertain who were the earlier functional equivalents of GPs, who made the decisions about admissions to a psychiatric bed? How did the proto-general practitioners make these decisions before 1948, and how applicable is the model to earlier periods of care?

The overall historical development of general practice in Britain has been fully covered by Digby (1999) and by Loudon et al. (1998) – Loudon himself being a former GP – but there is virtually no reference in these books to the role of general practice in the care of the mentally ill. Likewise in the many histories of psychiatry in Britain, little reference is made to the role of general practice. Surprisingly, in a 2021 chapter titled ‘Clinical perspectives on community and primary care psychiatry and mental health services’ in the recent historical volume edited by George Ikkos and Nick Bouras, less than a page is devoted to primary care psychiatry (Turner, 2021). The comprehensive text on Primary Care Mental Health edited by Linda Gask and colleagues (2018b) similarly has half a page on the history of the field. I have reviewed the literature on GPs involvement in mental health up to 1980 (Hall, 2022), and in June 2022 a witness seminar was convened by Alan Cohen, Andre Tylee and Lydia Thurston to cover the period from 1960 to 2019 (Cohen et al., 2023).

## **Applying the model to patterns of psychiatric care from 1834/1845 to 1959: public, philanthropic and private systems of healthcare**

Histories of psychiatry in Britain have paid most attention to the network of publicly-funded lunatic asylums – later usually known as mental hospitals - which was created from 1845, and grew to around 100 large hospitals in England. There were however three other classes of institution which accommodated people considered to be insane or mad.

From c.1600 parish workhouses had accommodated numbers of insane people, particularly those deemed harmless and including those with learning disabilities, among the elderly infirm and chronically sick. A small number of charitable, or voluntary, asylums grew from the 1750s, one of the last to be

opened, in 1885, being Holloway Sanatorium at Virginia Water in Surrey. Lastly, the madhouses were private businesses run on the basis of profit, and were later known as licensed houses (Parry-Jones, 1972).

These four categories of institution were funded and administered in different ways, with differences in the way in which they were regulated legally, reflecting social attitudes of the period, but also leading to differences in the pathways by which people were admitted, and the filters through which they passed. The pathways to care and the filters for the public asylums were closely linked to the 'new' poor law system which was introduced in 1834, so they will be considered together. Peter Bartlett (1999) has made clear the close interaction between the Poor Law and Lunacy systems.

By the end of the nineteenth century, an overall pattern of services was set that essentially remained in place until the two reform dates of 1948 and 1960. Some administrative structures changed later in the nineteenth century. For example, the 1888 Local Government Act replaced the previous jurisdiction of JPs by elected county councils and county borough councils, which took over responsibility for managing both public medical services and the public asylums. The 1890 Lunacy Act was focused on concern about wrongful detention, so introducing a complex system of orders and certificates, and the necessity for a magistrates order in every certified case. The main components of this pattern of care were the available institutions, the key staff groups, and the legally-conferred decision-making powers of those staff groups.

## **Pathways of care to the workhouses**

The 1834 Poor Law Act and the 1845 Lunatic Asylums Act together introduced a totally new principle into the funding of healthcare in Britain, which was the central government imposition on local authorities of a requirement to provide services according to a defined pattern, but this requirement was limited to services for those defined as 'paupers'. The 1834 Act remains one of the most significant pieces of social legislation in British history. It was based on two principles: to control the cost of poor relief, and to address what were perceived as the worst aspects of the old system.

The Act created 'Unions' or groups of parishes, managed by a Board of Guardians, made up at least one representative from each parish, and any resident Justices of the Peace (JPs). They were required to build a workhouse and to appoint a specified group of officers. The officers appointed included a clerk to the Board, the master of the workhouse, a medical officer, and one (or more) relieving officers. Little published historic attention has been paid to the relieving officers.

Apart from an unpublished PhD (Mishra, 1969) on the history of relieving officers 1834 to 1948, the only other recent relevant publication examines the work of mental welfare officers post-WWII, who were the functional descendants of the ROs (Rolph et al., 2003). The part-time medical officers were appointed after a competitive tendering process, where the Boards of Guardians looked to appoint the person at the lowest price, even when that price was well below the going rate (Longmate, 2003). By the end of the century, the originally part-time poor law, and public health, posts became full-time in larger towns, so the GPs occupying those posts became full-time salaried local authority health employees.

It was the job of the relieving officers and medical officers to ascertain those people in the community who might need relief and to be admitted to the workhouse or to an asylum. The usual process was for the first contact with the potential inmate to be with either the relieving officer or medical officer, who would then make a recommendation to the weekly meeting of the Board of Guardians. 'Harmless' lunatics (including those then classified as 'idiots') could be admitted to the workhouses. If a workhouse inmate became so disturbed that they were unmanageable, the workhouse master could initiate a transfer to an asylum, which also required a medical certificate from the union medical officer. So the decisions of the workhouse master, working alongside his wife the matron, together with the doctor constituted another route to the asylum. If a person in the community was considered both lunatic and dangerous, they could be admitted directly to an asylum.

So the Poor Law Union medical officers, mostly part-time appointees from local surgeon-apothecaries were, with the relieving officers, the gatekeepers for paupers to the workhouses, the private madhouses and the few asylums that then existed, with the workhouse masters involved in transfers from the workhouses. In all cases, the medical superintendent had no control over who was admitted to the asylum, although they controlled discharge (see Bartlett, 1999, pp.98-99).

The decision to admit to a workhouse was finally ratified by decisions of the Boards of Guardians – should they be considered as another filter? One objective of having a member of the Board from each parish was to enable the Board to understand local circumstances behind an application for relief, but this objective could only be met if the representative of that parish was present, and if the decision-making processes of the Board meetings allowed that to happen.

## **Pathways of care to the asylums**

In 1845 the Lunatic Asylums Act required the erection of an asylum at public expense by all English and Welsh counties and boroughs. Most asylums were built

over the period from 1845 to 1900: as the demand for additional beds increased remorselessly over the century, every public asylum was expanded and secondary buildings were added. The network of large public mental hospitals that was created by these Acts was essentially complete by WWI (Runwell Hospital in Essex was the last complete mental hospital to be opened in 1937), and became the largest specialist provision for mentally ill people until their decline from the 1950s. The accompanying 1845 Lunacy Act established a national monitoring body, the Commissioners in Lunacy, and each asylum was required to have a resident doctor. The senior resident medical officer was usually termed the medical (or physician) superintendent, who was both the senior clinician and the overall manager of the asylum. Their duties were specified in detail, including ensuring detailed documentation of each case, which was included in the mandatory annual reports submitted to the Lunacy Commissioners. The rapid growth of the asylum system meant that most of the new asylum doctors were surgeon-apothecaries by background, as both the conditions of employment and level of salary were not attractive to the ‘gentlemanly’ physicians.

The union medical officer and relieving officer would identify potential lunatics for admission, often through information provided by families, neighbours and clergy, and a further medical certificates might be required, and after 1890 a JP then had final discretion whether to ‘certify’ the person as insane.

Thus the decision to admit a person to a public asylum from their community of origin usually involved at least three people: the union medical officer, the relieving officer, the doctor providing the independent medical certificate, and from 1890 the JP. The procedures were different for those admitted to the voluntary asylums, with a family member being required to ‘apply’ for admission.

But what did any of these doctors, in general practice, as poor law doctors, or as asylum doctors, know about lunacy? In 1841 the *Association of Medical Officers of Asylums and Hospitals for the Insane* (later the Medico-Psychological Association – MPA) was formed, with an accompanying journal, the *Asylum Journal of Mental Science*, appearing in 1853. The first English textbook *A Manual of Psychological Medicine* by John Bucknill and Hack Tuke was published in 1858. While lecturers in mental pathology were appointed at medical schools from around 1870, not until 1885 did the General Medical Council say that teaching on lunacy was even desirable for medical students, and it was only to become compulsory in 1893. In 1911 a Diploma in Psychological Medicine (DPM) was introduced by a number of medical examining bodies, and this remained as the standard post-graduate qualification until superseded by the Membership Examination of the newly established Royal College of Psychiatrists (MRCPsych) in 1970.

Various attempts were made to create formal classificatory systems of disorders from the early nineteenth century in several European countries (Berrios and Porter, 1995). These relied on ‘expert’ opinion until attempts were made in the late nineteenth century to agree standard systems. The MPA created a list in 1882, and this was revised by their Statistical Committee in 1904, which commented on how deficient the earlier list was. George Savage (medical superintendent at the Bethlem Hospital) in a section in his 1890 book first cites an ‘ideal classification’ accepted by the London College of Physicians, and then goes straight on to expound his own system (!), which he does admit to being ‘provisional’.

Until the beginning of the twentieth century there could thus have been no expectation that *any* doctor had formal knowledge about lunacy, or was following any widely agreed system of classification, and up to WWI no expectation that an alienist (psychiatrist) had any formal training. So their expertise in distinguishing between different presenting conditions would have been limited, with wide discrepancies in the threshold levels of disturbance seen as warranting admittance to the workhouse or asylum.

## Comparing pathways

Against this historical background, we can now examine the assumptions underlying the position from 1834/1845 compared to the original 1980 formulation of the pathway model. Firstly, those assumptions varied according to the financial status of the individual concerned, with the critical difference being between those who were paupers and used the poor law and public asylum systems, and those who either personally, or through access to charitable resources, could pay for other forms of care or access philanthropic funding, leading to parallel sets of pathways.

### Pauper pathways

- medical primary care only available through the poor law medical officer
- secondary psychiatric care only available from a public asylum, or from a private madhouse (later licensed house) paid by the Board of Guardians
- no assumption of any formal level of medical competence, except for apothecaries from 1815, until the Medical Act of 1858
- no commonly agreed system for agreeing diagnosis, so no basis for agreeing on what constituted a psychiatric ‘case’

## **Private or charitable pathways**

- medical primary care available through dispensaries, free or subsidised, or by payment, by physicians (some identifying themselves as neurologists), apothecaries, or surgeon-apothecaries
- the first specialist psychiatric out-patient department in Britain opened in 1918 as the Hospital for Nervous Diseases (linked to the Bethlem Hospital), to encourage triage of new referrals to the hospital in order to differentiate between treatable and untreatable cases (Killaspy, 2006). Out-patient clinics developed rapidly, and they evolved to provide community follow-up of discharged patients
- secondary psychiatric care available from a licensed house on payment, or from a voluntary asylum, either charitably or on payment
- level of knowledge and diagnostic systems as for the pauper pathways, but with higher-status physicians available, although no certainty that they would be more competent than apothecaries

## **Applying the model to patterns of psychiatric care after c.2000**

Since the 1970s the pattern of NHS mental health service provision in Britain has changed in a number of ways. Single-handed GP practices have virtually disappeared, with multi-partner health-centre based practices now dominant, usually with other mental health practitioners on site. The old large mental hospitals managed by their own HMC have disappeared, to be replaced by multi-site services, with separate bases for a range of specialised and generic multidisciplinary teams managed by much larger NHS Trusts.

Alan Cohen (2005) has written a very helpful short review of primary care and mental health over the period 1985-2005, pointing to the importance of the 1972 RCGP report on the future direction of general practice. From 1976, GP Principals have been required to have vocational training, and vocational training has become mandatory from 1983. In 1987, the World Health Organisation developed a framework for the classification of mental disorders in primary care, ICPC WONCA - now ICPC-2 (Gask et al., 2018a). The range of 'effective' interventions available within the NHS has broadened, to include a range of psychological interventions as well as medication, and there is increasing availability of support provided by a wide variety of charitable agencies, and of private-practice mental health services. Crucially, the composition of both primary care staff and the staff of secondary – and tertiary – mental health services have undergone ma-

for change, with increasing availability of community psychiatric nurses, clinical psychologists and counsellors.

However, the range of new mental health policies inaugurated by the 1999 Adult Mental Health National Service Framework (NSF) have arguably had the most radical impact (see [Glasby et al., 2021](#)). Following the NSF, a series of detailed Policy Implementation Guides were promulgated, which required mental health trusts to create a new set of specific-function teams, including for example early intervention teams for psychosis, each with their own objectives and crucially with their own clinical acceptance criteria.

New practitioner groups have been created, an important example being graduate primary care mental health workers (GPCMHW). This role was created to assist with the management of common mental health problems, but it was not initially clear how they should be employed. It was not clear to what degree they would work autonomously, or at what stage in patients' illness journey they would intervene ([Bower, 2002](#)). Another important example is the introduction of the Improving Access to Psychological Therapies (IAPT) programme, providing brief psychological therapy delivered by specifically trained IAPT practitioners. The implication of these changes is that the first contact a patient may now have with a dedicated mental health practitioner will not necessarily be with a psychiatrist.

A further development, at the same time, was the establishment in 1999 of the National Institute for Clinical Excellence (NICE), whose initial function was to develop 'evidence-based' practice guidelines, identifying the interventions for specific conditions that were both clinically- and cost-effective. The first clinical guidelines were issued in 2002, with one of the first being on schizophrenia. While the acronym remains NICE, the full title of the organisation is now the National Institute for Health and Care Excellence, indicating the extension of its remit.

Putting all of this together, the assumptions underlying NHS mental health provision since c.2000 are:

- Universal availability of medical primary care through a member of the primary care team, who may not be a doctor, free to the patient at the point of delivery
- Universal availability of secondary psychiatric care, accessed through a range of mental health practitioners working in specialised and generic teams
- Assumption of levels of practitioner competence through formal and regulated training and professional registration, and public and political confidence in that competence, but with practitioner decisions regulated by practice guidance

- Assumptions about what practitioners agree to constitute a psychiatric ‘case’ defined by formal criteria
- Regulation of practice by the 2007 Mental Health Act and 2007 Mental Capacity Act
- The introduction of a ‘regulatory culture’, that refers not only to the formal bureaucratic mechanisms that pertain to institutions, such as rules guiding the development of NHS services or constraints on funding, but also to the ethics, aesthetics and ontologies that surround them. They shape an actor’s sense of how things should be done and what is an appropriate way of organising or coordinating activities. Regulatory culture influences what might be expected to be therapeutically effective, what might count as therapeutic effectiveness, and how therapeutic effects might be conceptualised. Even if it is sometimes unacknowledged and might fall under the radar of favoured research methodologies, regulatory cultures originating outside biomedicine can play a crucial role in the history of mental healthcare (Armstrong and Agulnik, 2023).

## Conclusion

The Goldberg and Huxley pathway to care model is a powerful instrument for examining the clinical decisions made by primary care and mental health practitioners about the transitions of individual service users between different elements of services. It helps to identify exactly who makes which decisions, and the factors operating on those decision makers. The model can be modified to take into account different directions of travel through a service network, and additional filters can be identified.

The model can also be applied to understanding how additional levels of mental health care have emerged, so that the associated filters between them have changed over time, and how the key individuals for those filters have changed. It then becomes apparent that the detail of the 1980 formulation was most applicable between 1948 and c.2000. Applying the model to practice from 1834/1845, the roles of both the Union medical and relieving officers at the proto- second and third filter levels are clear, with the role of the workhouse masters also important. The decision processes during that period depended on the economic circumstances of the putative patient, and involved members of more groups than commonly understood.

Applying the model to the period after c.2000, what is most apparent is the increasing influence of a ‘regulatory culture’, at one remove from the immediate clinical encounter. Practice guidelines and more formal criteria for admission to

discrete services reduce the discretion of the individual practitioner, who may now come from a range of professions of origin, and who may not have a full professional training.

The model is a powerful conceptual tool for understanding how mental health systems function, and points to referral and transition decisions as of central importance in the clinical role of mental health practitioners alongside those of assessment, treatment and review. It is flexible and can be modified, not only to accommodate differences between national mental health systems, but also historically. While some of the assumptions underpinning the model are of their time - the period between c.1960 to c.2000 - it can be applied both retrospectively to explore the functioning of British mental health systems from their inception from 1834, and prospectively to understand the changes from 1999 – and beyond?

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