Few research projects in community care take place in the patient's setting rather than the psychiatrist's. For instance, of 49 research papers published in the September, October and November issues of the *BJP* in 1995, 38 were based on samples of patients in hospital, or attending "psychiatric facilities" – hospital or clinic. Eight were unclassifiable. Only three were based on samples in community settings – one drawn from prison, one from general practice, and one from patients interviewed in their own homes. This last came from Canada.

The hospital or clinic is, of course, the most convenient place for carrying out small psychiatric research projects. Contributors to the *BJP* often commend the short questionnaire – "easily completed in 15 minutes". Questionnaires are framed with the aim of obtaining precise and unambiguous answers from respondents. The figures add up. The results are subjected to the standard statistical tests – χ^2 tests, *t*-tests and multiple regression analysis. The paradigm, as in other branches of medical research, is the randomised controlled drug trial – admirably scientific, admirably exact; hard data which is persuasive to grant-giving agencies; but when the research method is applied to less amenable material, studies often miss their mark. Opinions, attitudes, emotional reactions are more difficult to elicit. Data collected at speed from distressed and often confused people who have come in search of help may have little validity. Responses to pre-set questions requiring binary Yes/No answers, or to a Likert scale may be given almost at random. To ask patients to respond to a prefabricated questionnaire during a brief and traumatic episode of their lives may be to ignore the reality of the situation as they experience it. Too many such questionnaires are motivated by the research workers' desire to prove their facility a "success" – often for funding reasons. "Consumer satisfaction" is the name of the game, as in Tesco's or Sainsbury's; but psychiatry's consumers cannot shop elsewhere, and are often not very clear about what they are buying.

Research which is genuinely community-based may be more difficult to mount, more time-consuming, and more expensive; but it is time we made a start on the methodological problems. A rapprochement between psychiatry and the social sciences is long overdue. There are research concepts and techniques in the social sciences which might provide a way forward to more realistic approaches: see, for example, Bulmer (1986, 1987), Walker (1985), McCracken (1988), Gilbert (1993) or May (1993). There are possibilities of more varied research design, more sophisticated sampling methods, other methods of data collection, and the use of a much broader range of secondary data which could help to free psychiatry from the straitjacket of the clinical paradigm.

Perhaps psychiatrists designing research projects on the effects of community care might ponder Schumacher's distinction between convergent and divergent questions.

Convergent questions are those which permit of exact answers, like "What are two and two?". Divergent questions are those which involve balance and judgement, like "Should I send my child to private school?" or "How can I better understand what this facility or this treatment does for patients?". Schumacher (1973) says

> "The true problems of living . . . demand of man not merely the employment of his reasoning powers, but the commitment of his whole personality".

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Professor Kathleen Jones, 44 West Moor Lane, Heslington, York YO1 5ER

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