Correspondence

'Bridges over Troubled Waters'

DEAR SIRS

I am very concerned about some of the points made in Dr Peter Wells' short article 'Cut Price Adolescent Units that meet All Needs and None' (*Bulletin*, September 1986, **10**, 231–232). I am particularly worried that the generally dismissive views expressed of the HAS Report, *Bridges over Troubled Waters* might allow our fellow professionals to ignore some important and quite radical proposals in that document.

It would be very unfortunate if our colleagues in Social Services and Education, who also work with disturbed adolescents, were encouraged to believe that the medical profession do not take the HAS Report seriously. I would agree with Dr Wells that the Report is naive in one particular respect, in that the writer of the Report did not grasp the political nettle, and make a firm statement about the need for extra finance.

Having said that, however, there is much that should be taken notice of by all of us in the Report. Above all is the powerful and repeated statement, quite radical in its implications, about the need for a comprehensive service for disturbed adolescents. It recommends that such a service can only be provided by co-operative planning and liaison between Health, Social Services, Education and the Voluntary Sector, and that such planning should be conducted at all levels of administration. Only by liaison and planning at the highest levels in the various agencies concerned will it be possible to ensure that there are no gaps in a comprehensive service through which a difficult adolescent, or one with a poor prognosis, could slip through. The Report continually returns to the need for joint planning, joint research and even to joint finance for adolescent services.

Dr Wells' anxiety that there will be explicit pressure on NHS adolescent units to admit all kinds of psychiatric problems needs to be examined carefully. It is well known that those adolescents with a formal psychiatric diagnosis form only a tiny minority of the vast numbers of disturbed adolescents in the community. It is also likely that it is that tiny group of disturbed adolescents that require a more medical approach to their treatment, and possibly in-patient treatment in an NHS adolescent unit. The bulk of the disturbed young people in the community probably require something much less medical, and are in fact best treated and helped in the community and not in hospital-based or NHS adolescent units. This is not to say that there are not many doctors and nurses who can offer the very best service for behavioural and emotional disorders. But many other professionals are just as skilled and could, with help, training and support from adolescent psychiatrists and their colleagues, provide as good a service to a much larger number of adolescents, and in surroundings that do not carry such overtones of medicine and madness.

Most child and adolescent psychiatrists use a dynamic, developmental model of personality and of psychiatric disturbances. They see behaviours and disturbances as an expression of the interplay of nature and nurture, and such an understanding underpins the various treatment approaches that we use. A family or dynamic orientation must be a *sine qua non* when attempting to understand the psychiatric problems that come to us, whether these problems are of an emotional, conduct, behavioural or formally psychiatric kind. It is only by applying such a dynamic understanding even to the most difficult of psychotic problems that a proper diagnostic formulation can be made, and appropriate plans for treatment prepared.

The diagnosis of acute psychosis in adolescence is an extremely serious and difficult matter, and such a diagnosis needs to be made with great caution, and only by a child and adolescent psychiatrist who has experience of these rare conditions, and who is aware of the implications of such a diagnosis. I view with the gravest concern the suggestion that the suspected psychotic adolescent should be passed to an adult psychiatrist for observation and diagnosis, and possibly treatment in an adult ward; not least because it is likely that a totally different conceptual approach will be employed by an adult psychiatrist.

I see the future of NHS in-patient services for adolescents as becoming inevitably more orientated towards the treatment of the more serious formal psychiatric categories. If these groups of adolescents are at present felt to be often unresponsive to treatment, then it is our responsibility as psychiatrists to find ways of treating them and caring for them more effectively. For the bulk of disturbed and disturbing young people suffering from conduct, behavioural and emotional disorders, they will be increasingly treated in the community, or in jointly staffed establishments, with the support and guidance of child and adolescent psychiatrists and the health care workers. This is nothing new, except that there must now be an active commitment from all the agencies concerned to work together to plan and create comprehensive interlocking services for disturbed adolescents.

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The clockwork parrot

DEAR SIRS

As you have given Dr Horrocks two opportunities to answer my original letter (*Bulletin*, May and June 1986, **10**, 115 and 145) and have now published a rather unexpected letter from one of our former students (*Bulletin*, September

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1986, **10,** 247) I feel emboldened to make some further observations. Dr Stout describes our letter as "vociferous" and Dr Horrocks mentions "bluster and moving goal-posts". I have re-read our original letter (*Bulletin,* February 1986, **10,** 36) with some care, and would ask other readers to do the same, to see whether this pejorative language is in any way deserved.

What we asked was whether the HAS has evidence for its strongly held beliefs. In reply, Dr Horrocks denies that his Service has any such beliefs: thus advice is not imposed, and appeals are not necessary. Our experience has been otherwise. The HAS Report seems to us to reflect a strongly held ideology that is unsupported by any very good evidence. In our case, the Report has been used by our DHA as justification for its present plans to reduce psychiatric beds at Withington from 189 to 105 beds: only 30 or so of these are to be replaced at another hospital.

Dr Horrocks protests that local considerations are given great emphasis by his teams. In our experience, and in the experience of the many NHS consultants who have chosen to write to me directly, this is not the case: the clockwork parrot strikes again. The particular local consideration given virtually no consideration by the HAS, by our NHS planners—and now, it seems, by one of our former students—is the necessity for a major teaching hospital to engage in teaching the subject. If Dr Horrocks is able to show where he took this need into account, let him pick up his pen for a third time.

I am naturally pleased to hear that Dr Stout has had good experiences with the HAS, and I am aware of others who can say the same. I never had the pleasure of having Dr Stout work on my Unit during his training: had he done so, he would have known that the second opinion work done by a Professorial Unit is to the advantage of both patients and consultant colleagues in the Region, and he might have learned to check his facts before rushing into print. Regular readers of the *Bulletin* may by now be forgiven for supposing that our own Department has more medical staff than Salford: this is not the case, as I mentioned in an earlier letter (*Bulletin,* April 1985, **9,** 83). May I remind Dr Stout that if one constructs a national league table for manpower, then 31 mental illness hospitals have more consultant staff, and 88 hospitals have more nursing staff, than ourselves: in each case his own service is well above ours in the list.[1]

Dr Stout should save his sympathy for colleagues in the Standard DGH Units of the North West, who are severely under-resourced—as I have pointed out with supporting figures.[2] The remedy for such under-provision is not to weaken services in areas that have allocated a reasonable proportion of their resources to mental illness, but to put pressure on DHAs with poor services to divert resources into mental illness.

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REFERENCES

[1]DEPARTMENT OF HEALTH & SOCIAL SECURITY (1985) *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England.* London: HMSO. pp. 44–50.

[2]GOLDBERG, DAVID (1986) Implementation of mental health policies in North West England, in *'The Provision of Mental Health Services in Britain—The Way Ahead* (Eds. G. Wilkinson & H. Freeman. London: Gaskell (The Royal College of Psychiatrists) see esp. p. 63.

'The Wisdom [sic] of Deterrence'

DEAR SIRS

As a former Professor of Psychology in other Universities and a Member of the General Council of the University of Edinburgh, and as an Associate of the RMPA/RCP of some 30 years' standing, may I be permitted to comment upon the article, 'The Wisdom of Deterrence', by Dr Ian Deary (*Bulletin,* July 1986, **10,** 165–168).

One is stunned at the psychological objectivity that can discern analogies with men's nuclear weapons in sheeps' horns (bighorn sheep, admittedly), and with multilateral nuclear disarmament in children's cake-sharing theory (?); that can think in terms of an "0.04% for a cruise missile", and of "a critically *low* level of warheads"; that can see the fact that "both sides accepted that each had the potential and the willingness to destroy each other's civilisation" simply as a "refined concept"—and not as evidence of psychosis or psychopathy. But it is impossible to overstate the trivialisation which Dr Deary has brought to this, the major issue of our time. The level and tenor of his article are those of a schoolboy debate.

Dr Deary (paragraph 1), kicking off with an unwarranted assumption and red herring (Dr Dyer was writing in his own personal capacity, of course, as is Dr Deary), passes on the most frightful and frightening instance ever of the *post hoc ergo propter hoc* logical fallacy (viz "the policy of deterrence has kept the peace in Europe for 40 years"), together with a complete irrelevance ('supported by every British government since the end of the 1940s') and an outdated statistic ('still supported by the majority of the British electorate'—this is even less true of the Scottish electorate).

After trying to score with a cheap jibe (paragraph 2), Dr Deary proceeds to criticise Dr Dyer not for what he has said but for what Dr Deary *thinks* he *should* have said. It is he himself who misses the point about costs, while selectively ignoring, for instance, the research and development costs of nuclear weapons, and deploying unstated and unwarranted assumptions, non-sequiturs and statistics without sources (that we would need such a high level of "conventional strength", that we would have to reintroduce conscription if nuclear weapons were to be discarded, that nuclear weapons cost only 10% of the British defence budget, and so on).

By mid-way through page 166, we are into such arrant sophistry as to defy detailed comment. Both content and style have gone awry. Non sequiturs (e.g. that the realisation that there would be no winner in a nuclear war supports the policy of deterrence) and unwarranted assumptions (e.g. the nonsensical bit about Utopia; that we need to

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