with the scheme to make sure that it works satisfactorily.

A. C. P. Sims
Dean

'Why admit to a bed?'

Dear Sirs

While fully agreeing with Dr Wells' plea (*Psychiatric Bulletin*, July 1989, **13**, 342–344) that the adolescent psychiatric service should not be impoverished any further, I am concerned that his solution should be to make a strong case for the retention of adolescent in-patient units. He himself makes the point that in a time of government financial restraints we should look towards "innovative and creative alternative solutions for the treatment of disturbed adolescents wherever possible without admission to a residential unit".

He also believes that if all but the seriously mentally ill were excluded from in-patient beds this "could lead to a near extinction of the profession". I am not so pessimistic. It could well lead to a re-evaluation of how we deploy our scarce specialist resources, with much more of a focus on community work, but although this might threaten the existence of adolescent in-patient units, it would not undermine the profession of adolescent psychiatry. An argument could be put forward that if a specialist adolescent psychiatric service better served the whole range of adolescent disturbance, then our health service colleagues, and other agencies dealing with disturbed adolescents, may be more prepared to rally round in the fight for the resources we need. Locking the resources away in in-patient units, which are often seen by the other agencies as precious and are by their nature and organisation slow to respond to changing needs, is likely to continue blocking the effective building of bridges between agencies working with adolescents.

Clearly Dr Wells has worked hard to make his service available to a wider population than "all but the seriously mentally ill" but should adolescents who behave in a disturbed way as part of a dysfunctional family system or complex interaction of social and psychological factors be labelled "ill" by the very process of referral for admission to a hospital unit? Efforts have been made by some units (Bruggen *et al*, 1973) to reframe admission in terms other than illness by focusing on issues of parental or agency responsibility. However, at the end of the day the adolescent must be left with the question "If I'm not ill why am I in hospital?" The problem with an illness model is that it can disempower adolescents and their family or carers, as well as other agencies working with them. Only doctors and nurses can cure "illness"! Certainly there are occasions when the use of a medical model approach with a disturbed adolescent is appropriate, as in psychotic behaviour. However, these occasions are rare in relation to the total spectrum of disturbance shown. Surely it is illogical to use the medical model as a universal approach to adolescent disturbance when it is only appropriate in a small number of cases.

To carry the argument to its extreme, one may well ask why psychiatrists should be involved at all with disturbed/disturbing adolescents other than in the small number with psychotic behaviour. However, countering this argument, I feel that psychiatry has a special role to play when an adolescent presents with disturbing behaviour, by intervening at a point in the process when the question is asked (though not always explicitly) "Is this young person psychiatrically ill?". By definition psychiatry has the strongest authority to answer this question, or to reframe the problem in a more appropriate way.

Following the closure of our in-patient unit, which was one of two Regional in-patient units in Wessex, in January 1986, we have worked towards developing an effective Regional community service dealing with a wide spectrum of adolescent and family disturbance. Having no beds available has forced us to change our "we must have beds" mental set and try out creative alternatives. We have developed approaches such as school groups, day assessment and joint group projects with other agencies working with adolescents.

Out of 1133 referrals to our service since February 1986, less than 1% have been referred on to the Regional adolescent in-patient unit. One may argue that as we no longer have beds then the more severely disturbed adolescents have been referred to the remaining Regional in-patient unit instead. Our view, however, is that we are dealing with no less seriously disturbed adolescents now than we were previously, when as a service we did have beds.

More research is needed to compare different forms of intervention in adolescent psychiatry and we should not assume that one particular way of organising a service, though not appropriate at one stage, should continue to be so. Why admit to a bed indeed?

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Reference

Bruggen, P., Byng-Hall, J. & Pitt Aikens, T. (1973) The reasons for admission as a focus of work in an adolescent unit. *British Journal of Psychiatry*, **122**, 319–329.

Dear Sirs

I am grateful for an opportunity to reply to Dr O'Leary's response to 'Why admit to a bed?'. Closure

of one out of two in-patient adolescent units in his region compelled his team to find less costly ways of managing and treating disturbed adolescents than admitting them to beds. Although he does not describe what alternative approaches he uses, there are hints that a family centred basis may play a significant part, as it does in my own region. (To satisfy my curiosity, I would welcome an invitation to visit and he would be welcome to visit us).

I agree with Dr O'Leary about the need for a much broader compass in designing adolescent services than an exclusively medical one. However, he goes on to make the fallacious assumption that possession of beds necessarily implies the sole use of a medical model. Although many adolescent units do use it to a greater or lesser extent, no two units seem to conform to a standard pattern. Admission to my own unit, for example, is based on a negotiated agreement about change with the young person, parents (if available) and the referrer. Unlike more medically orientated units, drug therapy is rarely, if ever, used, and is largely replaced by modified therapeutic community methods. A second unit with a more medical approach is designed to treat mentally ill adolescents.

It remains true, I suspect, that once a health authority closes beds, it becomes much less likely that cases desperately needing admission will be referred. Shorn of the ability to make a fully versatile response and needing to maintain therapeutic optimism, it is tempting to conclude that beds are no longer necessary.

The situation in Dr O'Leary's region may be very different to what we are asked to deal with here, close to two large industrial cities. Although four-fifths of our referrals are dealt with in the community, there remains a small but hard core of young people in this part of the world who cannot be managed appropriately in any other way than by separating them for up to three months from highly damaging and destructive circumstances. No-one else can cope with them any longer. Once a week family therapy, for example, however bravely sustained, cannot offer sufficient control, understanding or opportunity to change. Intermittent treatment in the community of this hard core also deprives teenagers of an opportunity to learn in a specially structured residential community which can respond with the necessary immediacy to aberrant behaviour. In such adolescent units the scope for deploying many different techniques and skills at the right time is crucial. Use of the peer group as a potent therapeutic instrument also provides an invaluable learning situation. Deeply rooted serious behavioural and emotional disorders need a countervailing corrective experience by which both timing and intensity offer the optimum chance of success. Such conditions can rarely, in my experience, be reproduced by disparate groups of therapists working, for example, with a young person in a community home run by Social Services.

Our adult colleagues are concerned over the numbers of damaged adults incarcerated in the prison system who need psychiatric help but who are not receiving it. As adolescent psychiatrists we need to be concerned that with the closure of Social Services beds an increasing number of highly disturbed and treatable delinquents are similarly at risk. Reception into care may not be the answer either, and the excellent foster parent schemes may be unable to contain some of the more dangerously acting-out young people. Where else can they go? However enlightened courts may be, for example, they are unlikely to be persuaded to permit many seriously psychiatrically disturbed offenders to receive treatment in the community, and the intensity of treatment needed cannot be satisfactorily provided by a *visiting* team, if the offender is placed in non-therapeutic accommodation.

Some teenagers may be so damaged by sexual abuse that they cannot be safely managed in a purely residential establishment, with or without sporadic therapeutic intervention. Over the last year we have had to admit several girls who have become self-mutilators and unmanageable after sexual abuse. We have also treated a number of teenagers who soil or smear faeces, rendering them difficult to place anywhere else in the community.

In my own two regions with a catchment area of $5\frac{1}{2}$ million, it is simply not possible to treat this hard core of very damaged children in the community with sufficient intensity to effect much change. As my article pointed out, we do operate a fine screening system to ensure that we admit only those who prove impossible to treat in any other way.

I agree with Dr O'Leary that an adolescent service needs to ensure that as few as possible treatable youngsters slip through the mesh. In my view, for the service to be comprehensive, it needs a versatile range of options, rather than one based on a unitary approach, such as the medical model, or a family therapy one.

Administrators, desperate to save money, grasp at straws. I hope that none of them will be convinced by Dr O'Leary's letter that they can now close adolescent unit beds with impunity. It would certainly leave our own two regions impoverished in our capacity to respond to needs appropriately.

The efficacy of treating *all* such cases in the community is unproven; the cost to society if their treatment is ineffective must be very high. Surely when dealing with this group of very seriously disturbed and acting-out teenagers we must continue to use well tried methods that *are* shown to be effective until

the alternatives posed by Dr O'Leary can be shown to be at least as successful?

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Asylum, asylums and rehabilitation

DEAR SIRS

Several speakers at the rehabilitation session of the Royal College's 1989 Annual Meeting and, a few days earlier, at the Netherne Annual Rehabilitation Study Day, discussed the challenging problems of long-term severely disabled patients in the era of care in the community. Unfortunately, the debate tended to confuse two separate, though interrelated issues: the need to provide long-term shelter and support (asylum) and the closure of large mental hospitals (asylums). Numerous contributors to the *Bulletin*, notably Abrahamson (1988) and Garelick (1988), have cogently clarified the argument for the provision of asylum as part of psychiatric services; this is a view shared by many concerned psychiatrists, and not that of reactionaries who cling to an outmoded ideology of institutional care. Nevertheless, there is little evidence that the mental hospitals' role of providing asylum to the group of severely disabled patients who need it is being effectively translated into community settings. The rapid run down of the hospitals has dictated the extent and pace of discharging such patients to poorly planned, inadequately resourced community environments, as pointed out in the statement by the Coordinators of National Demonstration Services in Rehabilitation (1987). Many of these patients do not receive the continued care, shelter and support inherent in good rehabilitation practice; homelessness, destitution, involvement with the police and lack of basic medical care are prevalent.

The reassuring statement by Mr Roger Freeman, Parliamentary Under Secretary of State for Health, which was issued to Health Authorities (15 June 1989), makes the point that the White Paper policy for the "development of locally based hospital and community services, including facilities providing long-term asylum for those who need it, and as a consequence the closure of very large mental hospitals, has remained essentially unchanged since, supported by successive Governments" and that hospitals should only close "when proper alternative locally based services are available". It has been evident, however, that there is often a gap between policy and implementation. It is for this reason that CONCERN (Care of the Neglected: Collaborative Education, Rehabilitation and Nursing) was formed, with the initiative of Dr Malcolm Weller (Lowry, 1989). CONCERN will act as a professional pressure group whose main aim is to encourage the slowing down of hospital closures so that the needs of severely disabled patients can be accurately demonstrated and until adequate community services are provided to meet those needs.

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Psychiatric appraisal for the Mental Health Review Tribunal – an algorithm

DEAR SIRS

At Mental Health Review Tribunals (MRHTs) a number of issues can arise which have general application to a majority of the patients seen. It is useful, therefore, for the medical member of a MHRT to cover the salient points likely to be relevant to the Tribunal at the pre-hearing psychiatric examination of the patient. For this purpose a set format, or algorithm, provides a structured record. This can be kept simple enough to be completed in a few minutes before the Tribunal and copies can be filled in or photocopied for the President and lay member of the MHRT. This approach might also be of help to Responsible Medical Officers (RMOs) who can assist MHRTs and possibly save themselves time and questions by presenting background information and details which the Tribunal will find of practical value in reaching a decision.

The following is a form of report which can be typed on to one side of standard A4 paper. Most of it is completed by just underlining the appropriate words applicable to the case.

D. A. SPENCER

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Reference

Mental Health Review Tribunals in England & Wales – A Guide for Members, 1988.