possible without a knowledge of psychodynamics? Why is psychodynamics, so much sought after in the psychiatric world, eschewed in adolescent psychiatry where it is needed most? What are the implications of this report for training and the future of adolescent psychiatry?

Whatever the answers to these questions, I believe that the HAS Report on the role of psychiatry and psychiatrists is anti-developmental and anti-progressive. The situation today is reminiscent of an era over two centuries ago, when Johann Joseph Gassner, Honorary Physician to the Court of Prince Bishop of Regensburg, was removed from his position. He was widely acclaimed for success in his treatment methods, and equally known for his honesty and sincerity. He was using the early psychodynamic techniques and had lost favour with the authorities.[1]

Finally, I would like to respond to the appeal of Professor Goldberg and others in the February 1986 *Bulletin*. Management acted on the recommendations of the Report before studying it themselves. I wrote a detailed response to the 'Review' report producing documented evidence to show it to be a misrepresentation. Independent responses were also written by the clinical staff and the nursing staff of the Unit. These responses were sent to the Region, relevant organisations and individuals. Several spontaneous letters to the Region from ex-staff of the Unit and psychiatric colleagues, who had worked closely with the Unit and knew it well, contradicted the observations and recommendations of the 'Review' report.

After many months, the Region decided to re-open. I remain its Consultant Psychiatrist and Medical Director. There is hope.

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REFERENCE

[1] ELLENBERGER, HENRI F. (1970) *The Discovery of the Unconscious, the History and Evolution of Dynamic Psychiatry*. Harmondsworth: Allen Lane/The Penguin Press. Pp 53–57.

DEAR SIRS

Dr Wells and Dr Steiner (*Bulletin*, September 1986, **10**, 231–232 and 246) offer criticisms of this report which I would like to defend. Our survey revealed that, with some striking exceptions, services for disturbed adolescents in England and Wales are uneven, piecemeal and palpably deficient in meeting the needs of many young people. The direct contribution which psychiatrists can make is an important element of the overall picture. It was disappointing to find that specialist adolescent psychiatric services were often isolated, unduly selective and failing to provide advice and support to adjacent organisations and disciplines. The 'elsewhere', to which Dr Wells' unit for instance directs psychotic youngsters, is unfortunately not universally guaranteed to provide appropriate treatment and support and it is good to see that Mersey RHA are taking steps to fill the gap.

Dr Steiner and Dr Perinpanayagam (above) regard the Report as biased because it fails to advocate a psychoanalytic approach to the problems of disturbed adolescents. The omission was deliberate: the Steering Committee believed that promotion of any particular philosophy of management could only lead to unproductive internecine argument which would obscure the real needs. Instead, as Dr Perinpanayagam acknowledges, the Report repeatedly advocates eclectic services which offer a range of therapeutic approaches. He must realise too that the intention of our recommendation that psychiatrists should have a primary responsibility for all those suffering from identifiable psychiatric disorder was to encourage greater "inclusivity" and to discourage the exclusion of such young people so frequently found today.

[Because Dr Perinpanayagam's letter refers to earlier criticism of the Health Advisory Service, readers of the *Bulletin* may be led to believe that the Review of the Brookside Young People's Unit which he describes was conducted by HAS. It was not].

Dr Steiner is critical of our failure to analyse the antecedent causes of adolescent disturbance. Such a task was outside the remit of a group striving to plan more rational services. But the Report calls specifically for research into child and family development, for longitudinal studies and for evaluation of preventive programmes.

Bridges Over Troubled Waters provides a clear description of massive unmet need and proposes an organisational and professional framework by which, for the first time, the needs of disturbed adolescents could be met comprehensively. The consideration which the College is giving to the recommendations is part of a national reappraisal of adolescent services which the Report has stimulated. An environment now exists in which psychiatrists can play a major role in adolescent service development and make well-reasoned bids for resources. Time will be wasted if it is devoted to partisan issues or defence of the indefensible current position.

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Psychotic adolescents

DEAR SIRS

We would like to express our concern about one particular issue raised by Peter Wells, Consultant Adolescent Psychiatrist, Macclesfield Health Authority, Young People's Unit, Macclesfield (*Bulletin*, September 1986, **10**, 231–232).

It would seem that most of his argument stems from the premise that psychotic adolescents cannot be managed with those having emotional or conduct disorders. We are not clear on what grounds he finds himself able to make this statement. Our own experience—admittedly limited by virtue of the small numbers—would indicate that psychotic young people are well tolerated by their peer

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group. Given proper encouragement by competent staff we would contend that such an arrangement can even be beneficial to both classes of patients. Surely also the fact that this group is so small and so vulnerable should preclude us from abrogating our responsibilities to them.

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Network community mental health care

DEAR SIRS

I find the ironies contained in Dr Peet's paper describing a 'network community mental health care' system (*Bulletin*, October 1986, **10**, 262–265) both amusing and dismaying. I spent two years in Canada (1983–4) as the Medical Director of a community and outpatient psychiatry service which had previously been run along exactly the lines described by Dr Peet. Network liaisons had been developed (one social worker spent almost all his time working out and supervising these liaisons, all clinic workers attended regular meetings with one or more social agencies), referrals were accepted by the whole team (two nurses spent almost all their time taking these referrals but not seeing the clients, 'intake meetings' were held to allocate key workers depending on the needs). 'Clients' were seen either in the Department or at their community base, or a discussion about them was held with the referral agency in order to help the agency deal with the problem; various indirect services had been set up. This community psychiatry service had been running for several years and was widely regarded as almost useless. I was asked to reorganise the system, which I did by introducing assessment and management meetings, doing away with the intake system, reducing the time spent 'servicing community liaisons' and increasing the time spent with patients. Since I was often asked what 'model' I was using, I called it the 'assessment and management model', though to myself I thought of it as the 'proper psychiatric practice model'.

I therefore find it frightening that exactly the sort of system which North America has been giving up in the last few years is being promoted so enthusiastically here. Dr Peet (whom I note has since moved on from the service he describes) starts his report by referring to the standard US Community Psychiatry Text[1], which he says indicates that the community mental health movement remains an important force in American psychiatry. I should like to quote from that book: "The bandwagon nature of community mental health, which dominated the field in the late 1960s, has long since past"—but not in the UK, we are just starting. Also: "Community mental health programs are in a state of crisis" and "uncertainty and even malaise hover over the field" and "the popularity of community-based services is rapidly deteriorating". (This last by Gerald Caplan himself) – again, not in the UK; we are undergoing unprecedented approval (at Governmental level) of the notion of community mental health and preventive psychiatry. It seems clear that we are now where the US was 10 or 20 years ago, except that we had, until the recent changes, a far better psychiatric service than the US did before their upheaval. I think that their upheaval was a genuine attempt to improve upon the appalling state of psychiatric service for the majority of US citizens. I think that ours is an NHS cost-cutting exercise backed-up by the enthusiastically anti-medical approach of many members of the multidisciplinary team.

No doubt I am swimming against the British tide at present – of course, as the tide comes in over here it goes out along the Eastern US coast! However, I sincerely hope that we can salvage what is left of our many worthwhile psychiatric institutions before they are swept away, leaving our patients drowning in a sea of professional net-workers but amateur psychiatrists. I also hope that Dr Peet's service will not be seen as a blueprint for others, who, unlike Dr Peet, already have good well-thought out services and units and who deal with areas which do not consist almost entirely of the young and middle-aged, rural middle classes.

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REFERENCE

SCHULBERG, H. C. & KILLILEA, (eds.) (1982) *The Modern Practice of Community Mental Health*. San Francisco: Jossey-Bass.

DEAR SIRS

I read with interest Dr Peet's article describing a model of community psychiatry (*Bulletin* October 1986, **10**, 262–265). In my quest for a consultant post I have visited a number of districts, the last of which had adopted an unadulterated community approach that has deserved the unanimous applause of the national press recently, and I thought that I would share with your readership some of my experiences.

During my visit I met a number of people and, going with the times, the general manager featured prominently on my list and it is my meeting with him that I think is most interesting. He outlined to me the nature of community services in the district and his complete opposition to any form of institutional care, which I was later told included hostels. He later expressed to me his views on the functioning of multidisciplinary teams which, in short, was that the team leader could be anyone who happens to "show leadership qualities" and as far as he was concerned the psychiatrist was just another mental health worker.

However, the best of it was still to come when he started asking me my opinions about ECT, which rather took me by surprise as this was not a topic I expected to be discussing with a hospital manager. Here is an example of a Griffiths-type manager who happens to hold strong ideological views regarding mental health policy who has found himself in a position of power to push them through independently of

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