merit much attention. Nor, until recently were they thought to be a proper subject for scientific research by doctors. Experience on our own unit and elsewhere has suggested that revision of both these views is overdue, and that they no longer provide us with an adequate reason to exclude all but the least seriously acting out youngsters from treatment.

It is certainly timely to acknowledge that treatment for some conduct disorders does work. Conduct disorders, emotional disorders and mixed emotional and conduct disorders comprise by far the largest consumer group, amounting to around 94% of the disturbed population of adolescents. Against a background of violent, delinquent and destructive behaviour by adolescents reaching epidemic proportions, there is understandably pressure on services to manage the relatively smaller group who are treatable. As adolescent psychiatrists, should we, as Tony Harbott suggests, pass them on to our social work colleagues with an offer of some training, or do we try and tackle the problem ourselves? If we do not tackle it ourselves, surely our own experience of the problem will be very limited and we will have little training to offer?

Those who believe, as I do, that adolescent psychiatrists and their teams need to develop a wider response to the demands of this very large consumer group, find that the needs of the much smaller 'diagnostic' group, particularly psychotics, cannot be met appropriately on the same unit. For one thing, consumer surveys have clearly shown[1,2] that the mental illness type adolescent unit is a strong deterrent to the majority of parents and young persons seeking residential treatment. What is even more worrying in my experience is that delinquents and other seriously acting out adolescents can make the life of a psychotic adolescent a complete misery, as they frantically try to 'drive out' madness from their environment. It is unprofessional in my view to expose mentally ill adolescents to such a devastating experience. What then is to be done with them?

Many can be satisfactorily treated in the community. There is also a strong case for each Region to provide a special in-patient unit for them, but where the NHS does not provide this facility, it is acceptable in my view to provide treatment on an adult ward once the adolescent psychiatrist has diagnosed the disorder. Tony Harbott seemed surprised that I should believe that adult psychiatrists are perfectly competent to treat psychotic adolescents, and possibly his experience in this regard has been less fortunate than mine.

The practical solution, surely is for the RHA to provide a *range* of units able to respond appropriately to the very differing needs of the main consumer groups, rather than as the Health Advisory Service Report, *Bridges Over Troubled Waters*, seems to suggest, warehousing them in *one* regional unit? Neither an indiscriminate admission policy, nor the highly selective one of admitting psychotics and other ill adolescents from the very small minority consumer group and possibly a few minor behaviour problems to a single regional unit will now suffice, however much work is done in the community to try and fill in the gaps.

Last year a District Health Authority proposed to condense three highly specialised units for adolescents at the Maudsley into two units. Political interpretation of the Health Advisory Service report is now likely to put other diverse and highly specialised units at the same risk.

What surely is needed, and what the Health Advisory Service failed to emphasise, is a more versatile rather than a more stereotyped service? This unfortunately is not politically expedient because it is costly. The HAS report failed to make a bid for increased financial resources, even to underpin its many excellent recommendations. What opportunities have been missed and how much at risk are we now placed as a result?

The Young People's Unit P. G. WELLS
Macclesfield Health Authority

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Personal reminiscences

DEAR SIRS

In recent years the *Bulletin* has published 15 personal reminiscences by distinguished psychiatrists in the 'Perspective', 'A Contribution by' and 'In Conversation with' series. It is of interest that only a third of the contributors made psychiatry their first choice speciality. The early aspirations of the others were to be: general physicians (3), neurologist, scientist, general practitioner, medical journalist, coffee planter and to have accommodation near the London theatres. One was reactive to an early debilitating illness.

Amongst the first switch-ons to psychiatry the influence of Aubrey Lewis is mentioned three times, D. K. Henderson is cited twice (also in relation to two other well-known academics) and reading Freud as a student, twice. The following early influences are also mentioned: C. J. Earl, Horsely Drummond, R. D. Gillespie, W. Mayer-Gross, D. Stafford-Clark and R. S. Woodworth.

One wonders whether the same diversities of backgrounds would be shown in profiles of well-known surgeons or physicians, for example? Also if a series on 'Famous Psychiatric Failures' would demonstrate similar early flexibility? Perhaps aspiring future contributions can be heartened by "I have failed more examinations than most people have taken", 'I spent most of my student time making music' and "Since qualification I have been a science degree drop-out and an idler on the Riviera".

It is to be hoped that the equivalent 'This Is Your Psychiatric Life' series of the 1990s continues to reveal such reassuring normality!

T. L. PILKINGTON

Department of Psychiatry
University of Leeds

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