deteriorating relationship" is too narrow. Firstly, there are additional important roles in the scenario: other people who can shift their own weight in the boat. Secondly, the context is of an increasingly financially constrained, centralised and authoritarian society, in which only the more exploitative aspects of individualism are fostered: a blustery gale in a choppy sea indeed.

The NHS is not composed solely of consultants and administrators; indeed it may be fruitful for a moment to cast other staff in the role of (more or less) dependent or individuated children. On this model, sibling rivalry between other professions for power, status, hegemony, etc., is being contained and acted out in the consultant versus administrator battle. Perhaps we shall see disputes in the 'lower ranks' involving clinical and administrative issues, which may then help the consultants and administrators either to pull together within the NHS, or finally separate (private practice).

The wider context, too, will also inevitably change. While financial constraints look set to tighten, it is by no means certain that the current emphasis on the economics of service delivery will continue to take precedence indefinitely over a medical notion which seeks to maximise the relief of individual suffering regardless of cost.

To add to Ian's prescription I would, in the mode of family rather than marital therapy, suggest that consultants and administrators could fruitfully get together to compare notes on the differences between the various pressures and constraints under which they respectively operate, and hope also that other staff will see fit to helpfully 'rock the boat'.

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Old case notes

DEAR SIRS

I wrote recently to a colleague at a particular clinic, asking him if I could borrow the notes of a child whom I had seen there when I was working in that clinic, whose younger brother had been referred to me.

I learnt to my consternation that a policy decision had been made by the clinic to destroy files on all patients when they reached the age of 25 years unless there were special reasons to retain them. The file I requested has, therefore, been destroyed.

I think this policy is an extremely unwise one. Many children with psychiatric problems grow up to have psychiatric problems as adults. It is of immense help to adult psychiatrists if they are able to consult the files of their patients when they were children. Furthermore, it vitiates any possibility of longitudinal research being done on these patients. Although the present staff of the clinic may not wish to do research, I think consideration should be given to enable those who come after to undertake this work. For example, a valuable piece of research has been done by Dr Zeitlin,[1] who has linked up the patients seen as children at the Maudsley with their attendance as adults at the Maudsley and has furthered our understanding of the history of psychiatric disorder.

I understand that for reasons of space such a decision was made, but surely alternatives could be considered, such as micro-filming, rather than a wholesale destruction of vital and important clinical material.

REFERENCE

[1] ZEITLIN, H. (1986) *The Natural History of Psychiatric Disorder in Children.* Maudsley Monograph No. 29. London: Oxford University Press.

DEAR SIRS

I have been sent a copy of the letter complaining about our policy to destroy the old files of our patients (after they are 25) unless there are special reasons to retain them. In that letter there is a sentence: 'Although the present staff of the clinic may not wish to do research. . . .'. This is offensive, and, as such, unacceptable; maybe we are interested in other kinds of research.

Also, her consternation would have been less if she had known that a circular was sent by the Department of Health and Social Security to Regional Health Authorities—HC(80)7 May 1980—paragraph 5b—recommending a minimum retention period of the records for children and young people until the patient's 25th birthday or eight years after the last entry if longer. It is what we do and, I suspect, many other agencies. The reason is the obvious one, the need for space.

However, I cannot disagree with the fact that sometimes it could be useful to have access to old files. But the alternatives suggested, like micro-filming, can be extremely expensive, and we must wonder if, in a time of expenditure cuts, a better use could not be found for the required amount of money.

(*Names and addresses supplied*)

The dilemma of adolescent psychiatrists

DEAR SIRS

My colleague, Tony Harbott, has written (*Bulletin*, January 1987, **11**, 25)—perhaps more in sorrow than in anger—to reproach me for my views on the selection of disturbed adolescents for treatment (Cut Price Adolescent Units That Meet All Needs and None? *Bulletin*, September 1986, **10**, 231–232).

The point of my paper was to emphasise the dilemma faced by all adolescent psychiatrists—if it is accepted that it is unreasonable to treat all categories in one unit, who should be excluded and what are the alternatives? In the past, most of us were taught that the treatment of conduct disorders, particularly those exhibiting personality disorder, is not really a medical responsibility, and that as a group they are not sufficiently responsive to treatment to

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?

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[1]JONES, R. M., ALLEN, D. J., WELLS, P. G. & MORRIS, A. (1978) Attitudes to a treatment experience for adolescents and their families. *Journal of Adolescence*, **1**, 371–383.

[2]PYNE, N., MORRISON, R. & AINSWORTH, P. (1986) A consumer survey of an adolescent unit. *Journal of Adolescence*, **9**, 63–72.

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!

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