unclear how the Overseas Desk is going to monitor not only the quality of training but the appropriateness of the training provided to these overseas doctors. "Mutual trust" as proposed by the Overseas Desk does not seem to be reasonable, given what is at stake. It is not clear whether there will be strict guidelines for those institutions which propose to take advantage of this scheme.

If guidelines are developed, will they dictate the nature of the training offered in order to ensure "... appropriate preparation for work in their own country"? Currently the College has an accreditation and approval system which reviews all training schemes. Is the College abdicating its responsibilities to overseas doctors by not providing a special accreditation and approval system, which would include individual arrangements between consultants and other training schemes, as exists for the career posts? Will there be an independent body monitoring all schemes with foreign doctors which has the power to withdraw accreditation should it be found that the training offered is inadequate?

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DEAR SIRS

I wish that Drs Araya and Moodley had asked the College Overseas Desk to send them documents of the Overseas Doctors Training Scheme before writing their letter. They would have found that several of their questions have already been answered. Please note that the phrase in their third paragraph – cannon fodder – refers to American psychiatry and not British.

The PLAB test is not waived for doctors coming on the ODTS, they have exemption on the grounds of (a) qualifying at a medical school recognised by the GMC, and, (b) having their proficiency in English guaranteed by their sponsors. This is both more reliable and more appropriate than the PLAB test for trainees who have been working in psychiatry at home.

The Overseas Doctors Training Scheme of the Royal College of Psychiatrists was set up before publication of *Achieving a Balance*, and of course *Achieving a Balance* has not yet been implemented. It is unfair to suggest that the ODTS was a response to attract overseas doctors purely for manpower reasons.

Drs Araya and Moodley quote my more recent *Bulletin* article on the Overseas Desk but take it out of context. In fact the aim of the ODTS is to make sure that training is now appropriate for overseas doctors. We would agree that basic training in psychiatry should be delivered locally and we require for the ODTS that doctors from overseas have worked for a year, and preferably two years, in psychiatry in training centres in their own countries. This, of course, was not possible for the previous generation of pioneers from overseas, who received all their initial training in psychiatry in Britain and then returned to their own countries.

There is clear and readily available information about how the Overseas Desk will monitor the quality of training which Drs Araya and Moodley could easily have obtained. The Overseas Desk will be asking the scheme organiser about the trainee's progress at regular and stipulated intervals; the trainee is asked to comment on the quality and relevance of the training received; and the overseas sponsor is also asked to make a comment when the trainee returns home. What is also completely clear is that there are strict guidelines for training scheme organisers receiving doctors on the ODTS. These are available to College members.

Guidelines have been developed and do aim to make training appropriate for doctors returning home. However, this is not an easy matter to resolve for many different reasons. The doctors on the College ODTS are placed only on schemes that are fully approved for training and only on those schemes that also have career registrars as well as visitors. The College is not abdicating its responsibilities; the needs of overseas doctors are being considered by the approval teams. The College is able to withdraw approval from training schemes; it may decide that training schemes should not receive College sponsored doctors on the ODTS; it is able to withdraw its sponsorship from the overseas doctor; it could refuse to accept a senior psychiatrist as overseas sponsor. The safeguards are there; it is up to all of us concerned

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

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Dear Sirs

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

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