by advertisement in the media.[2] Smokers were categorised into three groups reflecting their previous attempts to stop smoking, and an identical antismoking intervention was applied to each. Smokers who had made more attempts in the past had a higher point prevalence of smoking cessation one and six months later. They also reported significantly higher numbers of attempts to stop.

To increase our understanding of the process of stopping smoking, studies should include a measure of subjects' previous attempts to stop. If previous attempts to stop were found to be a consistent predictor of stopping, simple questions about previous attempts could be incorporated into clinical practice. These would indicate to general practitioners which smokers were most likely to respond to advice, facilitating the effective targeting of health promotion activity.

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Future of inpatient adolescent psychiatric units

NHS reforms address existing deficiencies

EDITOR,—Harold Behr and Matthew Hodes are right to be concerned about the future of inpatient adolescent psychiatric units,[1] but I believe that they are mistaken to cite the purchaser-provider split as the cause of the problem. The NHS reforms have simply highlighted longstanding deficiencies in the service offered by some inpatient adolescent units.

In 1986 the Health Advisory Service's report *Bridges Over Troubled Waters* described how in many parts of Britain difficulties had arisen as a result of a divergence between the therapeutic orientation of inpatient units and the expectations of referrers.[2] The report recommended that units should abandon exclusive admission policies and a single therapeutic approach in favour of a more eclectic model to widen the range of disorders treated.

In a survey of past and potential referrers to an adolescent inpatient unit in the North Western region the message from referrers was clear.[3] They wanted a prompt response to emergencies within a comprehensive assessment and treatment service for adolescents with mental illness, with psychotic disorders given the top priority. Interestingly, child psychiatrists placed a relatively low priority on the provision of services for sexual abuse and conduct disorders.

In the new NHS, if inpatient adolescent units are to survive they must adapt to provide an accessible service that is responsive to the needs of referrers. It is not sufficient for units to believe that they are doing good work; they must convince stakeholders in the outside world. Too many adolescent units have been perceived as expensive, insular, and expendable. A successful service needs to convince purchasers and referrers of its skill in assessing and treating major psychiatric disorder of early onset and its ability to offer emergency admissions, short inpatient stays, and assertive community outreach programmes.

The growth in private inpatient provision is simply evidence that an appreciable proportion of NHS units are still failing to adapt their service to meet the needs of those who refer severely mentally ill adolescents. The service sector has many disadvantages, including high costs, limited community and outreach services, and minimal opportunities for training and research. It is therefore in the interests of patients, purchasers, and the specialty of adolescent psychiatry for high quality inpatient services to develop within the NHS. Child and adolescent psychiatrists must act collectively within regions to lobby purchasers and providers to support and develop adolescent inpatient services that meet their needs.

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Hill End Adolescent Unit

EDITOR,—In their letter on the future of inpatient psychiatric adolescent units Harold Behr and Matthew Hodes refer to the specialist psychiatric adolescent unit based at Hill End Hospital and state that it has closed.[1] This is incorrect. Hill End Adolescent Unit, as it is more commonly known, has temporarily suspended its inpatient service while a new consultant is appointed, but it continues to work with families and referrers, on a consultation basis, and as a day service for difficult adolescents. The inpatient service will resume after the new consultant takes up the post.

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Marginal analysis in practice

EDITOR,—We congratulate David Cohen on two counts: firstly, on achieving formal acceptance of a framework for assessing purchasing priorities and seeing this through to changes in contracts; and, secondly, on achieving a disinvestment list of 10 areas.[1] Many purchasing authorities seem to have no framework (some even seem unaware that they need one), and clinicians can be reluctant to consider disinvestments.[2]

Cohen emphasises that the composition of the working group in the first stage needs careful consideration because the process is value laden. Despite this he gives no explanation of the group's composition. The group seems to have been professionally top heavy, yet this pilot involved an area in which consumers' views are particularly important. The inclusion of purchasing staff (who were omitted from the Newcastle group (N Craig *et al*, joint conference of Faculty of Public Health Medicine and Health Economists' Study Group, University of York, January 1993)) would help to ensure that available evidence was used to question, and when necessary challenge, local practice in purchasers' priority areas.

The second stage of the process is only briefly dicussed, yet this is arguably the most important part of the whole exercise when the evidence on costs and benefits is assessed. The Cochrane reviews highlight the need to undertake thorough searches of all published evidence and the importance of skills in critical appraisal of literature. Cohen's paper, however, does not discuss the adequacy of these processes in the exercise in Mid Glamorgan. Furthermore, the paper describes a rough analysis of costs when what are required are prices, from current and potential providers, for the proposed changes in activity.

The paper does not state who was involved in generating the benefit criteria—again a value laden process for which the composition of the group is critical. The criteria can be questioned: "distance from target" on the grounds that targets may be inappropriate; "numbers treated" because it reinforces the emphasis on activity and not health gain; and "severity of condition" because it implies a direct relation between severity and benefits, which is no more robust than that between total needs and relative priority. Moreover, two important criteria—namely, equity and effectiveness of treatment (as opposed to strength of evidence of effectiveness)—have been omitted.

Finally, a false dichotomy is presented between total needs assessment and marginal analysis. For example, an analysis of expenditure and activity in relation to demographic and epidemiological data can identify major anomalies in the current use of resources at the macro level, on which to focus marginal analysis (N Craig *et al*, programme budgeting and marginal analysis workshop, University of Strathclyde, Glasgow, 29-30 September 1994). Needs assessment, in its many forms, is therefore complementary to, and not in competition with, marginal analysis.

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Author's reply

EDITOR,—Alan Mordue and Neil Craig's criticisms provide useful advice on how applied marginal analysis can be improved. The experience in Mid Glamorgan, however, was put forward not as an exemplar but simply to show that marginal analysis can work in practice. It also showed how setting priorities on the basis of the economic principle of weighing the marginal gains and losses from any changes in current patterns of expenditure is better than setting priorities on the basis of alternative methods—in particular, total needs assessment. My fear is that such detailed criticisms may give the impression that others should be wary of attempting to conduct their own marginal analysis exercises until they are sure that they have the machinery in place to get them right.

For example, the authors' criticism of our use of rough data on marginal costs may suggest that success depends on the availability of accurate data on marginal costs and, presumably, on marginal benefits too. While accurate data are obviously better than rough data, one of the key messages from our experience is that applying the right framework is more important than using accurate data. Much can be achieved by simply ensuring that relevant data on costs and benefits are considered, even if they are rough, and the non-availability of accurate data need not preclude use of the technique.

Similarly, the composition of our group may