Chapter 8

Services for the Adolescent in the United Kingdom

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INTRODUCTION–DEFINITIONS

Adolescence may be defined as the period of development between childhood and adult maturity. It is difficult to be more precise about this period in terms of chronological age as it consists of naturally phased periods of further growth and development following on those of childhood which have an intrinsic variability. The onset and course of adolescence are influenced by constitutional and a variety of environmental factors such as nutritional, social, cultural, climatic, and psychological. Onset, i.e., the lower limit, is marked by the appearance of puberty which is initiated by complex hormonal factors which, in turn, are influenced by external environmental factors. Although there is remarkable sequential uniformity in the appearance of physical changes at puberty there is considerable variation in the chronological onset. Detailed study of adolescence, therefore, requires the concept of developmental age which is based on skeletal age, dental age, secondary sexual characteristics, etc. These factors, together with the rate of change and their emotional accompaniments, constitute the legendary adjustment processes which characterize this life epoch.

It is noteworthy that researchers have often utilized chronological age as a simple, convenient criterion of adolescence. For instance, some have used the operational criterion of the second decade of life (i.e., eleven to twenty inclusive) while others the teenage period (thirteen to nineteen inclusive).

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However, in view of the variability in onset and course there must be questions about the validity of comparisons, especially cross-cultural ones, which are undertaken without consideration of developmental age.

Turning to definitions of psychiatric disorder in adolescence, the clinician or research worker is confronted with problems which are probably greater than at any other period of life. As Henderson et al. (1971) point out, different observers "will perceive the same behavioral phenomena in different ways." Broad definitions with loose criteria lead to high prevalence rates, narrow definitions with strict criteria to low prevalence rates. At no stage of life are such rates more sensitive to differing concepts of illness, the politico-socio cultural frameworks of the illness (Kolvin 1974) (highly abnormal neurotic behavior or rebellion and dissident behavior can all too easily be labeled psychotic) and the importance of the distinction between "normal adolescent turmoil" and true psychiatric disturbance.

Indeed, while some assert that adolescent turmoil and crises are normal, others deny this (Masterson 1967; Offer 1969; and Offer and Offer 1969). Furthermore, not only do some think that adolescents do not spontaneously grow out of these states (Masterson 1967) but others have gone on to speculate whether they are precursors of schizophrenia (Rinsley 1972). On the other hand, Rutter and Graham (1973) deny the extent and significance of the *proverbial* family conflicts and communicational difficulties of adolescence, asserting that clinic experience has tended to give a generally misleading picture of adolescent difficulties.

CONTRIBUTION OF UNITED KINGDOM RESEARCH

The Size of the Problem

Point prevalence rates of psychiatric disorder in adolescence are difficult to achieve mainly on account of differences of definition of adolescence and acceptance of what constitutes illness, not only between cultures but often within cultures as well. Such factors may account, in part, for the rarity of scientifically rigorous prevalence studies at this age range. In the face of such difficulties some research workers have resorted to studying the use made of psychiatric services for adolescents to reach an estimated rate of disturbance. Other ways of overcoming such problems are to use standardized interview schedules (Masterson 1967; Offer 1969), Teacher and Parent Inventories (Rutter and Graham 1973) or Self-Rating Inventories such as the Cornell Medical Index (1949) or the General Health Questionnaire (Goldberg 1969).

Various methods, such as screen parent and teacher questionnaires (Rutter et al. 1970) and evidence gathered in a systematic fashion by community nurses (Brandon 1960) have shown that in the United Kingdom the percentage of children alleged to be suffering from psychiatric disorder to cover

a range from 6.8 percent (Rutter 1970) to 17.9 percent (Brandon 1960). A recent review (Garside et al. 1973) suggests a fair overall estimate of psychiatric disturbance consists of at least one child in ten. Studies of the referral rates of psychiatric disorders in adolescence have tended to use two main criteria, firstly at least one consultation with a psychiatrist and secondly that the incident occurred during the second decade of life (and most have excluded patients with I.Q. below 70). Results in the Aberdeen City Study (Kidd and Dixon 1968) showed an annual rate of referral to specialists' services of 6.6 per thousand at risk in the teenage population. Less than half of the patients were referred by their general practitioners. Half of the girls referred were seen at the request of the hospital service, the remainder being referred by their family doctor. On the other hand, the proportion of boys not referred by the family doctor was divided between those sent by the hospital agencies and by statutory authorities. These findings suggest that for young people social as much as clinical factors act as the primary determinants of referral (Kidd and Dixon 1968). Studies in Edinburgh (McCulloch et al. 1966; Henderson et al. 1967) show a referral rate of 5.6 per thousand at risk. In this series 30 percent of the boys and 37 percent of the girls poisoned or injured themselves before being examined by a psychiatrist. In contrast only 6 percent of the boys and 29 percent of the girls in the Aberdeen series were seen because of self-poisoning. This suggests that factors operating locally affect the rate of referral.

In the city of Newcastle Upon Tyne the hospital and community services are staffed by the same psychiatric personnel. Using information deriving from records we have calculated new case referral rates. The findings (Table 8-1) were that in 1973 there were few referrals up to the age of five.

Table 8-1. Referral Rates by Age and Sex

Age Range	*Male*	*Female*	*Total*	
Up to 5 years	17	14	31	(4.75%)
6 to 10 years	125	51	176	(26.9%)
11 years	29	13	42	(6.4%)
12 years	39	20	59	(9.05%)
13 years	37	18	55	(8.44%)
14 years	30	26	56	(8.59%)
15 years	27	24	51	(7.82%)
16 years	16	21	37	(5.67%)
17 years	14	25	39	(5.9%)
18 years	11	22	33	(5.06%)
19 years	16	20	36	(5.5%)
20 years	14	23	37	(5.67%)
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Thereafter there was a slow increase in numbers of referrals with a plateau in the low 40s at nine, ten, and eleven years. There is then approximately a 40 percent increase in younger adolescents, i.e., twelve, thirteen, fourteen, and fifteen, followed by the expected drop (see later discussion) for older adolescents. The other main finding is that the high male/female ratio for childhood begins to even out in mid-adolescence and then inverts in older adolescents. It is of significance that in spite of a comprehensive child and adolescence outpatient psychiatric service some 57 percent of the adolescents were initially referred to general hospital outpatient clinics (Table 8-2). Finally, there were some 36,000 school children in Newcastle in 1973 with approximately 3,000 in each age range. From census figures we calculate there were another 19,000 between sixteen and twenty years inclusive, i.e., about 3,800 at each age range. The overall consultation rate per 1,000 population at risk over the age of five was 12.6; at ten years 14.00; at thirteen years 18.3, but at eighteen years it drops to 8.7. An estimated mean rate for adolescence is 13.5 per 1,000, which is almost double the rates reported in Edinburgh (Henderson et al. 1967) and Aberdeen (Kidd and Dixon 1968).

Evans and Acton (1972) demonstrated an increasing referral to the adolescent psychiatric service in Edinburgh from 1966 to 1970. This showed an increase of rate of referral by 50 percent annually during the earlier years following the opening of an adolescent service to 20 percent increase annually after five years. Thus the later Edinburgh and the current Newcastle research underlines the dangers inherent in the administrative use of referral rates as indices of incidence. They can only provide a rough guide and closer estimates depend on ratios of referral rates to prevalence rates, but true incidence can only be determined from general practice or other epidemiological surveys. From general practice surveys and from an epidemiological study (Rutter et al. 1970) there is an indication that only about one in five children with disorders come for help. If such a factor of one in five is valid in adolescence then one can prorate and obtain a prevalence rate of about 3 percent to 6 percent. We will later present evidence that this is far too low, which suggests that a much higher ratio and hence multiplication factor is necessary in adolescence as compared to younger children.

Table 8-2.

Source	*Total*	*Age 11 – Children*	*Age 12 + Adolescents*
1. Hospital and Community Clinics specifically for children and adolescents	418	245	173
2. General Hospital Psychiatric Outpatient Clinics	234	4	230

Standardized interview schedules have been developed for adult research (Wing et al. 1967) and for selected adolescent groups in the United States only (Masterson 1967; Offer 1969). So far the General Health Questionnaire has not been used in the United Kingdom but Davies et al. (1968) have used the Cornell Medical Index in Australia and report that 11.4 percent of males and 23.8 percent of female medical students have significant psychiatric symptomotology. On the other hand, surveys of students in Belfast and Edinburgh (Caldbeck-Meenan 1966; and Kidd and Caldbeck-Meenan 1966) reveal rates of 9 percent for males and 13 percent to 14 percent for females. A more detailed analysis is provided by Ryle (1971), who estimates that serious psychiatric disorder affects 1-2 percent of university students in the United Kingdom during their undergraduate career, with a further 10-15 percent having emotional disorder of a level sufficient to require treatment.

In our opinion the most reliable and valid prevalence study of psychiatric disorder in the adolescent community in the United Kingdom is that of Rutter and Graham (1973) and this only refers to 14/15 year olds on the Isle of Wight. They report a corrected prevalence rate of 21 percent. However, as the rates at 10/11 years on the Isle of Wight, which is a stable and more affluent area of the country, proved low compared to those in London (Rutter et al. 1973) and Newcastle (Brandon 1960) we would suspect that this is a minimal rate, and that a fairer and probably more accurate overall rate would be in the region of 25-30 percent. It is interesting to note that, while the rate for conduct disorders was similar at 10/11 and 14/15 (and more common in boys at both ages), the rate of emotional disorders was much higher at 14/15, consisting mainly of anxiety states, phobic disorders, and also some depressive conditions. These disorders were more common in girls. They also report that psychosis was rare, which supports the Kolvin (1971) impression from his hospital survey.

To summarize there has been little in the way of specific studies of prevalence rates of psychiatric disorder at different age ranges of adolescents in the United Kingdom conducted with scientific rigor. It is not clear whether this is due to simple neglect or whether the subject of definition and classification in adolescence is so daunting as to deter even the most rash researchers from dabbling in this area.

Surveys and Follow-up Studies

Surveys of adolescent populations are particularly helpful for answering questions about:

1. the legendary rebelliousness and crisis phenomena of adolescence
2. the transience of adolescent psychiatric disorders
3. the efficacy of treatment.

It merits reiterating (Capes 1973) that the so-called "crazy mixed-up kid" adolescent type of crisis which was previously thought to be characteristic of adolescence has been questioned both in the United States by Offer and Offer

(1969) and in the United Kingdom by Rutter and Graham (1973). The latter researchers conclude that such generalizations appear to be based on findings with selected clinic populations.

In his five year follow-up of seventy-two disturbed adolescents, Masterson (1967) reports that three-quarters were at least moderately impaired at the age of twenty-one. A more elegant study was conducted by Rutter and Graham (1973), who report on the carry over of disturbance from pre- to mid-adolescence. Of those with conduct disorders at 10/11 years, 75 percent showed handicapping disorders in adolescence; while those with neurotic disorders at the earlier age, 50 percent were free of those with disorders at 14/15, one-third had previously had disorders at 10/11. However, about 50 percent developed their disorders for the first time at this age and were mostly emotional in type, mainly affecting girls.

Coming to treatment, so far no one has tried to emulate the Buckingham Child Guidance evaluative follow-up (Mitchell and Shepherd 1966) with an adolescent population. They compared fifty non-delinquent and non-psychotic children attending child guidance clinics with a non-treated, non-referred control group who were said to be comparably disturbed. Two-thirds of each group improved significantly. While the methodology of this research has been extensively questioned, (Rutter et al. 1970; Garside et al. 1973), one inescapable conclusion is that less severe degrees of psychiatric disorder in childhood often remit spontaneously. However, there is insufficient evidence to indicate that such improvement occurs with the more severe degrees of disorder.

In the light of the latter conclusion, it is interesting to note the findings of two follow-up studies of adolescents severe enough to be admitted to in-patient units (Annesley 1961; and Warren 1965). Annesley followed up adolescent patients some two years after discharge and Warren some five years after. Nevertheless, their findings are broadly similar with an encouraging prognosis in two-thirds to three-quarters of the group with neurotic type disorders, a moderate prognosis of 50 to 60 percent in the conduct or behavior disorder group, but a poorer prognosis in those with psychosis and brain damage. These are complemented by Capes' Study (Capes et al. 1971; Capes 1973), which emphasize the severity, the long duration, the unsatisfactory preschool home environment and type of disorder (all but two antisocial) of the nineteen adolescents with extremely poor prognosis of the 150 studied. She reports (1973) "one of the most significant facts to emerge from this survey was the very long history of disturbance in many of the cases . . . over half of the 88 psychiatric referrals had been a cause of worry to their parents before they were 6, etc." This again underlines the refractory nature of the more severe chronic disorders of childhood.

PLANNING HEALTH CARE FACILITIES FOR ADOLESCENTS

In any attempt to plan health care facilities for adolescents one needs not only reasonably precise information about the size of the problem but also the

potential use of the available services by the community. It is worthwhile examining the situation in child psychiatry where the above themes have been the subject of more intensive study. In 1955 a Ministry of Education Committee (The Underwood Committee) based its recommendations on evidence that 0.5 percent of the child population would actually be referred if adequate clinical facilities were available. In a later evaluation of services Garside et al. (1973) pointed out that in the 1970s at least 1 percent of the school population were attending either child psychiatry units or child guidance clinics and further argued that if such services were built up to more even levels throughout the country then closer to 2 percent than 1 percent of children would attend for treatment.

If we accept their estimate, i.e., that an overall prevalence rate of disturbance of children in the U.K. population is about 10 percent and if 2 percent of these attended psychiatric clinics, we can derive a prevalence attendance ratio of 5 to 1. We have also estimated that 20 to 30 percent of adolescents suffer psychiatric disorder.

If, as has been shown, that about 6.6 per 1,000 (approximately 0.7 percent) (Aberdeen 1968) to 13 per 1,000 (Newcastle 1973) of the adolescent population with disturbance attend for help, the question arises why 1 in 5 of children with psychiatric disorder attend clinics and why, at the most, 1 in about 20 of adolescents. There are a number of possible explanations, some of which we will develop at greater length. Firstly, studies suggest that social, subcultural, and clinical factors interact with psychological attitudes of adolescents in determining the pattern of usage of the available local health care services. For instance, the Edinburgh research reveals an inverse relationship between areas of the city where there was direct psychiatric referral, and areas where there were low rates of direct referral, but high rates of self-poisoning, which were associated with indices of social disorganization (McCulloch et al. 1966; and Henderson 1965). Secondly, compared with the child, who is taken to a clinic by parents, and the adult, who assumes responsibility for his own health, the adolescent is less likely to submit to the former, or to be motivated to undertake the latter. Thirdly, some workers have pointed out that some adolescents fail to recognize and may even deny the existence of evident disturbance (Rutter and Graham 1973) and even when they acknowledge disturbance, they have a variable reluctance to consult available helping agencies. As this is likely to be allied to anxieties about confidentiality, we believe it could be partly overcome if wider publicity were given to the fact that young people over the age of sixteen are entitled to medical confidentiality and that medical practitioners are not at liberty to disclose such information to parents or any other authority (social services) without the adolescent's permission.

In the child service, both Rutter and Graham (1966) and Ryle (1965) claim that the available services are dealing with the most deserving cases. We can only speculate that this is likely to be true, too, of disturbed adolescents. But this refers only to the tip of the iceberg and the crucial question is what about the remainder.

While there is ample evidence that when clinical services expand and improve, the use of services rapidly increases. This appears to be true, too, with psychiatric disorders in adolescence (Evans and Acton 1972). These authors also report that only one-third of their referrals come from non-medical sources. It would be therefore reasonable to assume that when the integrated community services for adolescents improve, the majority of disturbed adolescents will still by one means or another be channeled into one of the traditional medical services such as general practitioners or their equivalent in colleges or universities and referred on from these to the adolescent psychiatrist when necessary. In these circumstances, it is essential that primary physicians in the community colleges or universities have more training in the problems and disorders of adolescence and further, more psychiatrists need to be specifically trained in adolescent psychiatry.

In planning health care facilities for adolescents all the above factors and more need to be taken into account. Comprehensive community programs for adolescents should, therefore, include a network of services ranging from statutory to voluntary and formal to informal–such as orthodox hospital inpatient, day patient, outpatient departments, and hospital self-referral walk-in clinics on the one hand, to informal agencies run by voluntary bodies on the other. It is essential for these to be loosely integrated with parallel youth services in the community such as social services departments, probation departments, youth associations, educational psychology departments, school counseling services, etc. An account and critical review of such services in the United Kingdom follows.

Manpower

In a recent review Schonfield points out that in the United States NIMH statistics reveal that outpatient psychiatric clinics serve more persons in the 10-19 year age group than in any other decade of life. Similarly in the United Kingdom prevalence studies show that a high proportion of adolescents are in need of specialized psychiatric help, but at present specific adolescent services are less well developed. However, it needs to be remembered that as it is not possible to equate prevalence with demand (Rutter and Graham 1966; Rutter et al. 1970) the requirements for staffing cannot be based on prevalence rates alone. Indeed, from their epidemiological survey, Rutter and Graham conclude that of those children showing psychiatric disturbance, a third were thought to need diagnosis and advice only; a third possibly required treatment and a third *probably* required treatment. Further, these authors report (Rutter and Graham 1973) that at mid-adolescence many of those with clear problems did not see themselves as needing help and would not necessarily accept it, even if offered. Manpower estimates are, therefore, even more complicated in adolescent psychiatry. Allowance has to be made for the lower rate of acceptance of treatment, for the high dropout rates in treatment (Rosen et al.

1964; Rosen et al. 1965; Kidd 1968) and for availability and use of child psychiatric, adult psychiatric, and other helping agencies. While dropout rates are similar in the United Kingdom and United States (Rosen et al. 1969; Rosen et al. 1965; Kidd and Dixon, 1968) there is a sharp contrast in offers of treatment to new referrals of 33 percent in the United States to 66 percent in the United Kingdom.

Garside et al. (1973) describe a dramatic increase of social workers and psychologists working in child guidance clinics, but a very much slower rate of increase of child psychiatrists. In an attempt to correct serious psychiatric staffing deficiencies, the Ministry of Health doubled their senior training posts between 1968 and 1971. Nevertheless, it was clear that the modest target for consultant psychiatrists by a Ministry Committee in 1955 (Underwood Committee) of one psychiatrist per 45,000 school children has only recently been achieved (1971) in relation to psychiatrists. Subsequently the R.M.P.A. (Royal Medico-Psychological Association, 1960 and 1965) recommended as a realistic minimum, one full-time consultant child psychiatrist per 200,000 general population (35,000 school population). Garside et al. (1973) recommend two levels of manpower targets, i.e., an ideal to provide a comprehensive service and a realistic minimum. The ideal would consist of one consultant psychiatrist, supported by one psychologist and two social workers, so that in relation to the 1971 situation the minimal full-time equivalent staff necessary for clinical activities should have been 243 consultants, 243 psychologists, and 486 social workers. With the present rate of training, it is unlikely that such minimal levels will be achieved before 1975. In a subsequent document produced by the manpower committee of the RCP (Royal College of Psychiatrists 1973) the recommendations differ only slightly from the ideal and realistic minimum levels proposed by Garside et al. (1973) for a population of 200,000 and consist of:

1. Ideal Level—two consultants and supporting junior staff.
2. Realistic Minimum—one and a half consultants and supporting junior staff.
3. A further expansion of the senior training sub-consultant grade.

In the most recent draft memorandum on Adolescent Psychiatry produced in 1974 (R.C.P.—Child Psychiatry Specialist Section) it is recommended that the number of adolescent psychiatrists be increased to at least equal those of child psychiatry. This suggestion does not seem to take into consideration the fact that estimates of staffing needs for child psychiatry were based on both preschool and school population, the latter of which already includes a substantial percentage of younger adolescents. Furthermore, a variable percentage of the older adolescents or young adults will inevitably always be seen by general psychiatrists, particularly in areas geographically remote from specialized units. As such, we estimate that adolescent psychiatrists would maximally cope with 50 percent of the disorders in the second decade of life and

hence only about 25 to 30 percent of patient population in the first two decades of life. We therefore consider, in spite of the higher rates of disturbance in the adolescent section of the population, that a more realistic manpower estimate would be 50 percent of those recommended in child psychiatry.

While detailed statistics are not available, it is evident that adolescent psychiatry in the United Kingdom is one of the Cinderellas of the psychiatric subspecialties with ratios of adolescent psychiatrists to child psychiatrists running at 1 to 5 or more, rather than 1 to 2 as suggested above. There is little doubt, therefore, that establishment of training and consultant posts merit the highest priority in adolescent psychiatry as compared to general psychiatry and clearly even above that of child psychiatry.

We still need to indicate manpower recommendations in relation to nurses working in hospital adolescent units. As in child psychiatry, in adolescence there is unanimity of opinion that there should be a high nursing staff to patient ratios (about 1:1) together with permanence of staff in the adolescent unit (R.C.P. 1974; A.P.S.A. 1972). However, not only is there a major deficiency of trained staff even in established units, but there are also serious recruitment and training difficulties (Ackral et al. 1968; Garside et al. 1973; A.P.S.A. 1972). More recently a new National Nursing Board (Joint Board of Clinical Nursing Studies) has been established to plan curricula, monitor standards and accredit new or established postgraduate training programs (Brown et al. 1974) in the psychological management of children.

Provision of Facilities

Provision of health facilities for both children and adolescents in the United Kingdom was originally provided under the National Health Services Act (1946) and the Education Act (1944). Thus the facilities were based both on the National Health Service (hospitals) and the child and family guidance service of the local education authorities (community). This dualism has recently, in theory, been administratively resolved with the passing of the National Health Service Reorganisation Act, 1973, which came into force on April 1, 1974. The philosophy of the change and thus the intention of the Act is that the "health needs of the local community will be planned and provided for the first time within a single organisation. Local needs and priorities will be sorted and planned for in the context of national, regional and area plans" (Burbridge and Sichel 1972). The hope is for the establishment of a network of comprehensive health services which include both the community and the health service.

The child psychiatry services for children have been more fully developed than those dealing with adolescents. However, over the past ten years there has been an increase in the facilities for the latter. Thus services available under the Education Act catered for children of school age range up to fifteen for most children and eighteen to nineteen years for a small percentage. However, while community assessment and treatment of the early and mid-

adolescent age range disorders were theoretically available in a number of centers, in practice the techniques of treating adolescents were not fully developed. A similar situation was present in the health service. In practice the main facilities for adolescents were based on the health services and were dependent on local developments and the experience and the running of outpatient clinics both in hospital departments and in the community. Further, the R.C.P. document wisely suggests that there should be outpatient clinics at every major general hospital serving a district (major segment of the community). The opposite argument is that community- and education- (either school or university) based programs provide better opportunities for reaching young people. There is, as yet, inadequate knowledge and experience to support a dogmatic policy concerning the organization of such services. Preliminary favorable impressions from a major action research program in Newcastle Upon Tyne, whose main theme is redeployment of mental health personnel (including psychiatrists) into the schools leads us to advocate at least experimentation with a two-pronged service base. We therefore believe that there should be available mental health services existing within schools where adolescents could have access to all types of psychological and psychiatric help. This would hopefully reduce the grave dropout problems described in the literature. We also have the impression that some of the more uncooperative parents would allow their children to receive help provided they were not personally involved. In other words, where services are not meeting the needs of adolescents, it is essential to be flexible about the redeployment of our specialist services. This is not dissimilar to developments in University Health Services where some of the physicians who have had psychiatric training (Ryle 1971) patently function as adolescent psychiatrists. Such a policy accepts that both home and school (Power et al. 1972; Gath et al. 1972; and Pritchard 1973) exert potent formative influences on personality development and personal adjustment.

The function of the psychiatrist in such community-based services would mainly be that of a consultant to other professionals accepting mental health roles (educational counselors, year tutors, psychologists, social services staff, etc.). However, the consultant in the hospital-based service would accept responsibility for assessment and treatment of the more severely disturbed adolescents and have a lesser community consultative role.

Prior to the establishment of specific adolescent services, adolescents at schools were not referred directly to psychiatrists working in child guidance clinics or hospitals. Instead they came via two school sources, i.e., school physicians or school psychologist; and yet many adolescents were at the stage when they would have preferred opportunities for self-referral. More recently the Edinburgh Psychiatric Adolescent Service (Evans and Acton 1972) reported that about a third of their referral came from non-medical sources *including self-referral.* In adolescence, therefore, for multiple reasons, some of which we have already discussed in detail, we especially endorse the steady erosion of the

medical shiboleth that only medical practitioners may refer cases to consultant psychiatrists. However, for obvious reasons, there remains a strong case for sending a confidential report to the patient's primary physician, i.e., his/her general practitioner, to whom devolves the day-to-day medical responsibility.

The Educational Network of Services

It has been pointed out (Warren 1965; and Schonfeld 1971) that adequate psychosocial facilities for adolescents need to be based on a comprehensive and integrated network of hospital and community services. It is necessary to comment on the constituents of the educational networks which are available for the adolescent still at school. While the child guidance clinics with their team of educational psychologist, psychiatrist, and social worker have rapidly expanded in the United Kingdom, the other services are poorly developed. For instance, the educational counseling service within schools is relatively undeveloped, and the concept of a school social worker almost embryonic. Some of the larger secondary schools are seeking alternative ways of dealing with the major psychiatric problems confronting them. Some are exploring the use of special classes (adjustment classes) for maladjusted pupils, while others are experimenting with special classes for unmanageable (undisciplined) pupils. In addition there are the special schools for maladjusted pupils.

In 1968 statistics available from the Department of Education and Science revealed that 14.8 per 10,000 school population were receiving or awaiting special education. Garside et al. (1973) conclude that it is reasonable to suggest that as a realistic minimum, there should be twenty day or residential places per 10,000 school children for maladjusted pupils. It has currently become popular to estimate service needs in terms of a population unit of 200,000 which approximately includes some 35,000 school children. As about 30 percent of these will be younger adolescents it is not unreasonable to suggest that what is needed for them is one small special school. Furthermore, a general population of 500,000 would need about 50-60 places and could quite easily cater for a larger special school. As the Ministry of Health (D.H.S.S.) has already recommended twenty hospital beds per million general population for adolescents, it would appear that a total of 150 day and residential places could be considered as a reasonable, realistic minimum target for the next decade for a general population of one million. On the other hand, it needs to be appreciated that the expectations and demands from both parents and ordinary schools will rise as facilities increase, which may lead to increased demand. Further, there is evidence that many of the children currently placed in other types of children's establishments, or even what were formerly approved schools (correctional institutions), may be more appropriately located in maladjusted schools. Provision of such facilities has always to take into account geographical distribution of population.

Day and Residential Facilities in the United Kingdom

So far we have discussed the facilities for younger adolescents. In this section we propose giving an account of the range of facilities for all adolescents. Dependent on the age of adolescents, their special day and residential needs are served by a variety of settings in the United Kingdom.

1. Health Service settings—day and inpatient units.
2. Education Service settings—day and residential maladjusted schools.
3. Social Service settings—family group homes, community homes and hostels for working boys or girls.
4. Forensic (Correctional Service) settings--Those for younger adolescents have now been transferred to Social Services, and have been renamed community homes, while those for the young adults (borstal institutions) remain unchanged.
5. Combinations of the above, i.e., forensic settings within the health service.

In this section we will mainly concentrate on hospital settings. There is general agreement (Warren 1965; Henderson et al. 1971; Lancet 1968; and R.C.P. documents 1974) that separate inpatient services are essential for adolescents, both because of their potentially socially disruptive behavior and their special educational/vocational needs (Barter and Langsley 1968), and also as the principles of treatment of adolescents on a day or inpatient basis are sufficiently different from child or adult practice to merit separate facilities and handling. There is a further consensus view that some older adolescents are more appropriately and effectively treated on adult wards (Warren 1965; R.C.P. 1974). But arguments for the more general admission of adolescents to adult wards (Hansen 1969) because of the vitality they might inject into group therapy exercises are questionable. There is always the danger with such latter arguments that they constitute rationalizations for local expedients.

The development of day and inpatient units can be compared with that of the outpatient services. Such units often tend to reflect the training and experience and the philosophy of care of the local physician, and the local medico-political pressures to meet the particular needs, more than reflecting the characteristics and special needs of the local population. The units which have developed can be broadly categorized as follows:

1. Units for the more neurotic type of disorders. These are usually short- or medium-stay departments, offering intensive psychotherapy in a more permissive regime, and tend to treat the neurotic disorders of adolescents with a better prognosis. However, when cases with more severe disorders are admitted, short-term hospital admissions should be part of a long-term therapeutic plan.

2. Units capable of coping with psychiatric disorders with a significant acting out or antisocial component. Forensic adolescent psychiatric units also cater for some of the patients. Such units tend to use more structured therapy programs (Capes 1973).
3. Hostel units in which the adolescent may continue a normal or near to normal life style during the course of treatment. These tend to be informal, with little structure, and often rely considerably on group therapy.
4. Long-term units for more serious mental disorders.
5. The Ministry of Health (Department of Health and Social Security) has recommended the establishment of a small number of high security units in which severely disturbed adolescents, particularly those showing abnormally aggressive or seriously irresponsible conduct, may receive treatment. Unfortunately there are still few in number.
6. Special units for subnormal or borderline subnormal adolescents who additionally suffer from psychiatric disorder.

The Ministry of Health in 1964 suggested that, as an initial target, there should be 20-25 adolescent psychiatric beds per million population, which should be supported by day places and hostels. This works out at about 1,000 to 1,200 beds in England and Wales. Using the Register of Adolescent Psychiatric Units (A.P.S.A. 1973) we estimate that there were, theoretically, about 550 beds for adolescents, i.e., about 11 beds per million population. However, a percentage of these are located in "all-age" children's units, and are technically not very suitable for seriously disturbed adolescents. Thus by 1973 we were only halfway to the target specified in 1964 and, furthermore, there is substantial variation from region to region throughout the country.

Such conclusions can, of course, be misleading. For instance, more recently Bruggen et al. (1973) have advanced cogent reasons, such as lack of adequate peer models, disruption of long-term relations important for maturation, etc., for questioning the rationale of inpatient admission for younger adolescents. Nevertheless, the case for special units in each population area of the country is strong, but the number of beds required will depend on the extent to which community-based day and residential services as described above have been developed. A high proportion of adolescents can, in fact, be kept out of the hospital if there is adequate network of outpatient and other community services. While hospital facilities are more obviously indicated for the more clear-cut psychiatric disorders which require specialized nursing/medical supervision and treatment, a high proportion of disturbed adolescents (especially those requiring more in the way of environmental support) can and should be accommodated by the community services or by the outpatient services which can provide intensive psychotherapy. It is evident, therefore that no one unit can or would be willing to provide for the whole range of adolescent patients, but, on the other hand, a leader in *Lancet* (1968) warns that "too much diversity of

inpatient units might impair the cohesion of services in the local community." What has to be answered individually by each area is what is the correct pattern of services for the local community.

COMMENTARY

While over the last three decades there have been major advances in the development of mental health services for adults and moderate advances in those for children, it is only over the last decade that there has been an increasing recognition of the need for specific services for adolescents.

The case for such specific services has been strengthened by modern research consisting of epidemiological surveys and follow-up studies (albeit few in number), together with studies of the use made of facilities. Furthermore, the lowering of the age of onset of puberty has tended to magnify the contrast between childhood and adolescence on the one hand, and adolescence and adulthood on the other. Modern technology and rapidly changing life styles of modern society together with this early onset of puberty have served to highlight the psychological problems of this phase of life and, in consequence, have facilitated the appreciation of the need for such adolescent services. It is, however, likely that no small part of the awareness of the mental health needs of adolescents is due to direct or indirect increasing appeals for help by the young people themselves.

It is often asserted by those with particular training and expertise in adolescence that at no time in life does careful investment of skills produce greater rewards. Such views have led to recommendations of major expansion of mental health facilities to serve the adolescent population. In such a therapeutic climate there is the danger of a blind emulation of the child psychiatric and child guidance practices without benefiting from an appreciation of the shortcomings of such models (Rehin 1972; Levitt 1971; Eisenberg 1969; Carside et al. 1973). Simultaneously with service developments attempts need to be made to grasp the complex problems of clarification and diagnosis as an adjunct to studying the effectiveness of the diversity of services so that maximum support can be given to those developments which can be shown to be most psychologically and socially useful.

Further, as has been suggested in child psychiatry (Garside et al 1973) it is necessary to ascertain which disorders merit intervention by the sophisticated but expensive multidisciplinary teams and which, for instance, by the more economic but possibly equally effective use of community services which utilize psychiatrists in a consultative capacity only. Furthermore, there needs to be an appreciation and awareness that the diversity of developments described in this chapter must be in future based not on chance alone but rather on sound principles. These principles, in turn, need to be based on careful evaluation. Such evaluation should also apply to the different forms of therapy,

i.e., dynamic, behavior, and psychotherapy. It is fundamental to such evaluation of treatment and services in adolescent that there should be some attempt to define age adequate behavior which can be used as an index of maturation (Capes 1973).

Finally, it is necessary to emphasize that referral rates are useful to planners in that they provide an index of the use made of services by the local community. However, in no way do they constitute indices of incidence or prevalence. While it is helpful to know the prevalence-usage ratio for a particular community, rates dependent on such ratios can be grossly misleading when applied to other communities as both prevalence and usage vary widely, not only between, but also within communities.

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