*Adolescent Psychiatry in Britain: A Personal View of Its Development and Present Position**

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The importance of the adolescent life period, from 10 to 19 years, is evident increasingly in all cultures of the world. The short, ritualized transition from childhood to adulthood, which has been characteristic of some cultures, is giving way to more prolonged periods as the pattern of Western industrialized society spreads to other parts of the world. The mental health problems of adolescents are attracting increasing attention since they have long-term social and economic implications. In Europe and the United States, epidemiological surveys indicate a high prevalence of psychiatric disorders in teenagers. At all times in the community there is a large group of adolescents who are a source of concern because of their misbehaviour and apparent unhappiness. Nevertheless, adolescents world-wide have received relatively less medical and psychiatric attention than other age groups and specialized services, professional training and research are poorly developed. This is the state of affairs in many European countries and there are grounds for concern about the present state of adolescent psychiatry in Britain, in terms of both its clinical services and its professional development and status.

Historical background

Before the turn of the century, there was nothing which could be regarded as child psychiatry as it is known today. The literature on insanity in childhood and adolescence before 1900 was meagre, although during the second half of the 19th century most authors of psychiatric textbooks had started to include references to childhood disorders and both psychological and organic factors in aetiology were recognized. Puberty became regarded increasingly as an important physiological cause of disturbance and pubescent or adolescent insanity was referred to frequently. Throughout the 19th century, mentally disturbed children and adolescents, who could not be contained in the community, were accommodated in workhouses or in public and private asylums. It was not until the third decade of the present century, that significant specialized services for children began to take shape in this country. Separate services for adolescents were not established until after the Second World War and the first in-patient units for adolescents were opened at St Ebba's Hospital and the Royal Bethlem Hospital in the late 1940s. Subsequently, slow expansion took place until exclusively adolescent out-patient and in-patient services were developed rapidly in the late 1960s. This was in response to a Ministry of Health memorandum, in 1964, advising hospital authorities about the development of hospital facilities for the treatment of mentally ill and seriously maladjusted children and adolescents. At that time, there were seven units for adolescents in the country, with a total of 157 beds, catering primarily for adolescents suffering from psychoneurotic or behaviour disorders. It was recommended that provision for adolescents should be increased to 20–25 beds per million. In addition, the development of out-patient diagnostic services, provisions for day-patients, links with hostels and approved schools were all advocated. It was as recently as 20 years ago, therefore, that the structure of adolescent services of the present day was laid down. Whilst there had been increasing interest in the problems of adolescents since the last quarter of the 19th century, and child psychiatrists had always treated a proportion of adolescents, the growth of specialized adolescent psychiatry in this country was bound up with work in in-patient hospital units. This pattern resembled closely the emergence of psychiatry as a medical speciality, in the newly built asylums of the 18th and 19th centuries.

The initial service expectations of the new adolescent units, opened in the 1960s and early 1970s, were unclear and the responses were often highly experimental and influenced by very different ideas about the optimum form of the therapeutic milieu. Faced with very large catchment areas and the referral of potentially overwhelming numbers of disturbed young people, the clinical directors of the new units had to plan operational policies for these services and to make difficult choices about who to cater for and how best to run the units. Not surprisingly, services developed in very diverse ways, reflecting a wide range of theoretical approaches to the interpretation of requirements. Whilst the original decision to recommend regional in-patient units was a significant step forward, it led to many of the problems that are evident in current services for adolescents, particularly those resulting from the expectation that a single, all-adolescent unit could fulfil multiple functions. Although there has been a steady growth in the size and influence of the adolescent services during the last fifteen years, progress has been chequered by problems in the running and survival of some units. Generally, however, they have been integrated well into regional and district child and adolescent services and this model of the organization of services has become well established.

Some factors influencing the growth of adolescent psychiatry

Progress in psychiatry has not followed discoveries about causation and treatment in an orderly way. Instead, there have been a relatively small number of significant turning

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points and most changes have been related to wider social, economic, scientific and cultural factors and movements which are often too non-specific and slow-paced to be immediately recognizable at the time. This pattern has characterized the history of child psychiatry and has been evident in the short lifespan of adolescent psychiatry. In the midst of such changes, it is often difficult for the clinician to discern the most appropriate boundaries of clinical work or the optimum locus for intervention. The ever changing status of children and young people in society has been the essential formative influence on the growth of public services for children and adolescents and the expanding literature on the social history of childhood, adolescence, marriage and the family provides invaluable insight. Trends can be identified in the direction of more humanitarian attitudes towards children and young people, their rights as individuals and the importance of appropriate nurturing during early development and effective parenting. Changes in attitudes towards young people have been reflected particularly clearly in developments in education and legislation. Compulsory schooling in this country, for example, only began early this century, after which successive education acts raised the school leaving age to its present level. Similarly, there have been important developments in the forensic field, such as the raising of the age of criminal responsibility and the emergence of a training approach towards young offenders. The insidious growth of reliance on the state to fulfil many of the functions of the family has shaped the service expectations in the 'helping' professions, including child and adolescent psychiatry. Successive Children and Young Persons Acts, for example, have transferred increasing responsibility for the care and control of certain categories of children and adolescents to Social Services Departments. Important routes of origin for many contemporary views about residential psychiatric treatment may be found in advances in therapeutic education made by such pioneers as Rudolph Steiner. Similarly, the models of residential schools for maladjusted children and specialized therapeutic communities have had long-term effects and contributed greatly to the core of knowledge about residential treatment. Many schools had charismatic leaders who pioneered the concept of a democratic, self-helping community, which had a major influence on the notion of personal development.

As in the rest of psychiatry, clinical practice with adolescents has been influenced by a wide range of theories about the psychological and physical causes of mental illness. Psychodynamic approaches have been predominant, largely because they lend themselves particularly well to understanding problems arising at times of maturational change in adolescents and families. Finally, in understanding the therapeutic ethos of many of the earlier adolescent units, it has to be remembered that they were developing at a time of peak interest in the anti-psychiatry movement, when hopes were high that sociological models of disorder could replace the traditional, but worn-out, methods of the old mental hospitals.

Current strengths of adolescent psychiatry

(1) Manpower objectives of one consultant child psychiatrist per 200,000 total population, set by the DHSS over a decade ago, have been achieved nationally. The current target to provide comprehensive services for children and adolescents, proposed in 1983 by the Royal College of Psychiatrists, is at least two consultants per 200,000 population. However, there are substantial regional differences in the achievement of these targets. Only three of the 12 regions in England and Wales have reached the new target and seven are not more than half-way to its achievement. In addition, there are still a substantial number of vacant posts.

(2) There has been a remarkable increase in the number of units catering for adolescents since the mid-1960s. The 1981 Register of Units published by the Association for the Psychiatric Study of Adolescents included 61 units, comprising 54 general units providing 884 beds, 3 mental handicap units, a forensic unit and several day units. The exact number of all-adolescent units is rather smaller when children's or adult wards with groups of adolescent beds are excluded and, of course, the pattern has changed in the last few years.

(3) High standards of specialist training have been established and achieved largely in child and adolescent psychiatry. There are now 97 established higher training posts in 37 training schemes in the United Kingdom and Ireland, all of which are inspected and approved by the Joint Committee for Higher Psychiatric Training.

(4) The establishment of the Child and Adolescent Psychiatry Specialist Section of the Royal College of Psychiatrists has been an important development from a professional and academic point of view. It provides a valuable forum for the discussion of professional matters, and, undoubtedly, this is one of the strengths of the sub-specialty in this country.

(5) Multi-professional work has featured strongly in the development of adolescent psychiatry. This is apparent clearly in the Association for the Psychiatric Study of Adolescents, an influential multidisciplinary organization founded in 1969 and in the Association for Child Psychology and Psychiatry, established in 1966. The idea of interdisciplinary practice has influenced in a powerful way clinical work, teaching, research and the organization of services in the adolescent field.

Current deficiencies of adolescent psychiatry

(1) Despite the apparent richness of the provision of adolescent units and staffing, clinical services are variable and incomplete. This applies particularly to services for acutely disturbed adolescents, for emergencies, for community and long-term care. Whilst the overlap with services for younger children is generally adequate, that with

adult services is particularly unsatisfactory. It is all too easy to lose sight of the special needs of late-adolescents and young adults.

(2) Liaison between adolescent psychiatrists and paediatric and general medical services is far from uniform and does not match the degree of collaboration that often applies between child psychiatrists and their paediatric colleagues. The concept of adolescent medicine is not really established and the psychiatric attention given to physically ill adolescents is patchy. More widely, the co-ordination of mental health, education and social services is often inadequate, especially in the development of preventive programmes.

(3) The role and function of adolescent units can be problematic in many ways. Some units operate in a detached or even an isolated way with regard to parent psychiatric hospitals. Relationships with these hospitals have tended to be characterized by conflict about autonomy and resources and situations have arisen which parallel remarkably closely the adolescent's predicament in the family and society. Adolescent units have very special clinical and operational problems, concerned, for example, with the way in which adolescents can undermine and interfere with treatment efforts and with the ways in which they can test continuously the integrity, consistency and vulnerability of professional workers. Staff may be pulled in many directions and attitudes polarized in powerful ways. Whilst there is a clear need for the adoption, in individual units, of a theoretical model, this is often difficult to establish and to maintain. It is not surprising, therefore, that, over the years, some adolescent units have had a precarious existence or that problems should have arisen from divergence between the therapeutic orientation of units and the expectations of their function by outside referral agencies.

(4) Concepts of normality and abnormality in adolescents and the definition of psychiatric disorder are controversial issues. Accurate psychiatric diagnoses in disturbed adolescents may be difficult to make, particularly when there is a need to differentiate psychiatric disorder from essentially healthy, age-appropriate reactions that may settle when stress is reduced or eliminated with further personal development and the passage of time. In addition, there is often a particular reluctance amongst those who work with adolescents to diagnose psychiatric disorder and, instead, a tendency to focus mainly on evidence of disturbance in maturational processes and family dynamics and to classify disorders in these terms. As a predominant approach, this may not be in the best interests of adolescents, because it may mask the potential severity of the disturbed adolescent's condition and fail to indicate treatment needed to avert progression to major adult psychopathology.

(5) In view of the uncertainty about adolescent psychopathology and the ambivalence about psychiatric diagnoses in this age-group, it is not surprising that in-patient units have widely different admission policies and treatment programmes. In general, there has been an unhelpful polarization between social and psychodynamic ideas and therapeutic approaches, with relative emphasis on the idea of maturational breakdown and more conventional psychiatric work with the major mental disorders, habit disorders and handicaps. Many units have tried to resolve the problem by making substantial use of one particular conceptual framework or therapeutic approach, such as the therapeutic community or family therapy. Whilst this response may serve to consolidate staff attitudes and facilitate shared therapeutic objectives, it can have a restrictive effect on the scope of the service. For example, highly interactive programmes tend to exclude certain patients from forms of treatment which do not place special emphasis on verbal interaction. Similar restricting effects may result from the acceptance of the practice and ideology of family therapy as the basis of a total approach to work with adolescents, as opposed to its more selective use as the treatment of choice.

(6) Interdisciplinary professional work has featured prominently in adolescent psychiatry. It has had the benefit of allowing wide variation of experience and schools of thought to be brought to bear on adolescent and family problems. However, the multidisciplinary team is an unwieldy therapeutic device and it is questionable whether it is the most clinically efficient and cost-effective method of deploying scarce professional skills. It calls for substantial input of time and energy to ensure its stability and effectiveness, to avoid staff tension and the breakdown of communication. Problems about organizational relationships and the perennial issue of leadership by psychiatrists may generate disputes within multidisciplinary teams, which can undermine services and many clinics have been bedevilled by these problems. Social models of disorder and treatment lend themselves particularly well to multidisciplinary work and disorders which fit in less well with this model may generate difficulties. For example, clinical work with adolescents suffering from psychotic disorders may be complicated by the fact that the diagnosis and treatment of the psychoses is the traditional prerogative of doctors and nurses, by the empirical use of medication and because psychodynamic and family models of disorder may be difficult to apply.

(7) There are relatively few senior posts in all-adolescent psychiatry and it is difficult to disentangle staffing in adolescent psychiatry from that in child psychiatry as a whole. This raises the issue of whether or not there are grounds for a much clearer distinction between the two fields. There is no reason to believe that first class clinical psychiatrists make first class adolescent psychiatrists and vice versa. At present, adolescent psychiatry is practised by many psychiatrists with a substantial background in adult work and this has the benefit of retaining the focus on disorders of the older adolescents and the overlap with adult psychiatry. The currently popular model of higher training, in which child and adolescent psychiatry are closely inte-

grated, involves the relative exclusion of work with adults. This may well have the consequence of reducing the recruitment of consultant psychiatrists who have particular skill in working exclusively with adolescents, particularly those on the fringes of adulthood.

(8) Adolescent psychiatry is poorly developed in terms of academic manpower. There are only five professors of child and adolescent psychiatry in this country and many medical schools do not have academic departments of child and adolescent psychiatry. Inevitably, specific academic interest in the adolescent age period is bound to be limited. As a consequence, heavy reliance is placed on Health Service personnel for undergraduate and postgraduate training in this field. Linked with this is the fact that limited serious research is being undertaken. There are major research gaps in adolescent psychiatry, including such basic issues as the incidence and prevalence of disorders and the efficacy of treatment. Little time is left over for research in the working day in busy adolescent units and, in addition, the ethos of many units and the predominant staff interests do not encourage research. The body of theoretical and practical knowledge about adolescent psychiatry, therefore, has been slow in developing and, until very recently, there were hardly any specialist textbooks in the field. Formal training for adolescent health care personnel as a whole is far from satisfactory. In particular, there are insufficient post-basic training opportunities for nurses. Instead, reliance has to be placed on in-service training and, again, this is difficult to organize and sustain in small units.

Some conclusions

Current manpower levels in all professional disciplines and hospital provisions for adolescents make Britain one of the most advanced countries in the world. However, there is no room for complacency since services remain deficient in many respects. The model of the self-sufficient district child and adolescent psychiatric service, with specialist regional adolescent teams and in-patient units, is a good one and is generally effective. Despite the inherent disadvantages of regional, as opposed to more local services, especially in geographically large regions, there needs to be caution about planning district-based or sub-regional in-patient services unless these are determined by population density. Instead, it would seem appropriate to concentrate on developing the diversity of the regional adolescent services. These require a complex of provisions, ineluding long- and short-stay beds, emergency beds, day facilities and domiciliary and after-care programmes, with additional supra-regional services, such as secure units.

Professional staffing levels, the recruitment of appropriate personnel and the adequacy of training pose problems in many parts of the country and there is not likely to be an expansion in resources in the near future. Whilst this is the case, psychiatrists who have responsibility for delivering specialized adolescent services need to be rigorous in developing the scope and diversity of existing services. It is necessary to accept pressures to demonstrate that the psychiatric services delivered are of the highest possible quality and efficiency and to be prepared to move away from those planned on an intuitive hypothesis. Adolescent units are expensive to run and it is easy to argue that their cost-effectiveness is poor. In this respect, it seems that greater uniformity in the admission policies of in-patient units, providing for a wider range of disorders, would make better use of resources. In addition, with regard to clinical services, closer collaboration is required with medical and non-medical youth services, especially in promoting preventive and mental health programmes.

Although child and adolescent psychiatry are linked closely in the planning of services and the training of personnel, total integration may not be in the best interests of the adolescent sub-specialty or the quality of services. Instead, it can be argued that its separate theoretical and clinical identity needs to be clarified and strengthened. This should not lead to a split between the two fields, since development needs to be achieved whilst preserving the continuity of a close natural alliance with child and family psychiatry and, in addition, promoting closer integration with adult psychiatry. Adolescent psychiatry needs to be a unique blend of these two branches of psychiatry. Academic input into adolescent psychiatry requires urgent expansion and, similarly, greater priority needs to be given to research and to the training of medical and non-medical professional staff. In adolescent psychiatry, the clinician is led easily into many other medical, social, legal and ethical fields. The psychiatrist is a relatively recent participant in the affairs of disturbed adolescents and the contribution that clinical psychiatry can make has not been established clearly, alongside that of other professional disciplines. As a consequence, it is particularly important that the adolescent psychiatrist should be alive to the effectiveness and limitations of psychiatry. This is a necessary preliminary to full participation in inter-disciplinary practice and to making clear, rational decisions about the lives of disturbed adolescents.

The scope of adolescent psychiatry is wide, the definition of psychiatric disorder in adolescence is controversial and there is much variation in schools of thought about how best to understand and manage disturbed adolescents. The choice of the most effective approach, therefore, for the clinician's personal practice and the organization of services is a difficult task. In this respect, the clinical psychiatric model, with its emphasis on individual disorder and its treatment has many advantages, as the basis of a general approach for the psychiatric team working with adolescents. In view of the variable and incomplete nature of adolescent services, the predominant use of a single treatment model is too restrictive and an eclectic approach is the most desirable. In this respect, those working with adolescents need to be generalists, in both theoretical outlook and clinical practice.