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Review Article

The Future of Adolescent Psychiatry

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Background. Appraisal of the future of adolescent psychiatry is required urgently, in view of the increasing scrutiny of mental health service priorities and the need for informed planning of psychiatric training and manpower requirements.

Method. Future developments are set in the context of the changing concept and connotations of adolescence, the history and present position of adolescent psychiatry, and the rationale for separate services.

Results. Predictions are derived using trend extrapolation, in relation to a number of factors likely to determine the future. These include the social value attached to adolescence and youth, the status of adolescent medicine, the definition of clinical boundaries, the upper age-limit of services, investment in prevention, postgraduate training, research, the evaluation and marketing of adolescent psychiatry and, finally, its recognition as a separate sub-speciality.

Conclusions. Predictions suggest that adolescent psychiatry will assume an expanding clinical role and increasing academic influence in the 21st century.

At a time of radical reform in the British National Health Service (NHS) and far-reaching reappraisal of priorities in the mental health services, the therapeutic benefits and cost-effectiveness of adolescent psychiatry services are coming under increasing scrutiny. Furthermore, as the competitive purchaser–provider model has become consolidated, the income-generating capacity of psychiatric work with adolescents has been increasingly questioned. The justification for separate adolescent services has always been controversial, but doubts and criticisms about this field, especially its operational efficiency, should come as no surprise if some of its characteristics are borne in mind. For example, limited standardisation of interventions and wide variation in assessment and treatment styles – often without regard to cost – coupled with the lack of studies of treatment outcome and routine evaluation of intervention programmes, have made the services increasingly vulnerable to pressure for containing costs. This situation has serious implications for therapeutic innovation, and for the development, and even the survival of the services. Several in-patient adolescent units have been closed or threatened with closure, young adolescents are again being admitted to adult wards, and recruitment of consultants in adolescent psychiatry is often poor. For these reasons alone, an appraisal of the future of adolescent psychiatry is timely, albeit prompted by the challenge of changes in the system of health care funding and delivery. Further, such stocktaking is an essential exercise for those concerned with planning medical and psychiatric training.

Despite the important part played by multi-disciplinary work in adolescent health care, this review focuses strictly on adolescent psychiatry as a medical speciality; specific reference to the future of child psychiatry will not be made. This paper is concerned chiefly with developments in the UK, although these have much in common with the situation elsewhere in Europe and North America. When viewed from a global perspective, however, adolescent psychiatry presents an extremely varied picture, in which its absence or limited presence in many developing countries is related not only to the lack of funding for mental health services, as opposed to more urgent physical health needs, but also to sociocultural factors and legislative provisions for mentally ill adolescents (Earls & Eisenberg, 1991). This highlights the fact that the status and future development of any branch of psychiatry depend on more than just the prevalence, severity and treatability of disorders, and are influenced also by a variety of historical, social, economic, political and cultural factors. In forecasting the future of adolescent psychiatry, therefore, it is essential that attention is given to the concept of adolescence and its importance in

different societies, to the historical background of psychiatric services for young people, and to the present position of the subject both clinically and academically. Naturally, all predictions need to be made in the context of the future of psychiatry as a whole and require us to take into account changes in economic conditions, technology, demographics and social values. The methodology of future research is wide-ranging and complex. This review will extrapolate trends rather than construct scenarios or use simulation methods.

Concept and connotations of adolescence

In addition to the physical changes of pubescence and puberty, which mark the end of childhood, a phase of 'adolescence' has been recognised for centuries which extends from the completion of puberty up to young adulthood in the early 20s (Parry-Jones, 1994*a*). Demarcation of its end-point differs widely, and has been strongly influenced by social, cultural and economic factors, as well as behavioural markers such as the legal age of majority, defined simply by chronological age. In technologically advanced societies, 'adolescence' emerged in its present form in the second half of the 19th century, when it became associated with new stage-related problems, generated by prolongation of compulsory schooling and extended economic dependence on parents. This lengthy transition phase does not occur, however, in many parts of the developing world, and instead there may be a briefer, and often ritualised, passage to adult responsibility. As cultures become more complex, achievement of adult roles is increasingly delayed.

Adopting the age limits of 10–19 years in the definition of adolescence, as recommended by the World Health Organization (1965), has the advantage of incorporating the developmental transitions from childhood to adolescence (encompassing puberty) and from adolescence to adulthood. This is important because it is becoming evident that the latter transition can be more troublesome than the intermediate adolescent years themselves, as if the increasing postponement of adolescent problems heightens the difficulties to be overcome at the next developmental stage. This encourages the use of the concept of 'youth' for people aged 15–24 years, as an alternative to adolescence. However, if wider age parameters were utilised in service planning, the implications for adolescent psychiatry would be far-reaching.

Historical background

The recognition and treatment of mentally disturbed adolescents is not a 20th century phenomenon (Parry-Jones, 1994*a*). In the 18th and 19th centuries teenage lunatics and idiots were admitted routinely to private madhouses and asylums, where they were accommodated without any special age-related facilities. Clinical and academic interest in the mental diseases of young people increased steadily from the mid-19th century, and puberty became recognised as an important physiological cause of mental disturbance. By the close of the 19th century, serious attention was being given to the psychiatric disorders of pubescence and adolescence, particularly dementia praecox and manic–depressive disorder. Later, in the 1930s, the child guidance movement contributed to the delineation of a new multidisciplinary, child-orientated speciality, which moved away rapidly from the ethos of asylum psychiatry, developing instead an affiliation with paediatrics. While there continued to be interest in younger adolescents within its expanding clinical compass, the emancipated speciality of child psychiatry tended to abandon severely disturbed adolescents in asylums. In the 1940s very few mental hospitals had adolescent wards, and it was not until the late 1960s that there was a rapid expansion of regional adolescent units and associated out-patient services (Royal College of Psychiatrists, 1976; Parry-Jones, 1984). These were mainly developed in association with mental hospitals, in contrast to child psychiatry and child guidance services, which were housed in general hospital or local authority premises. The Association for the Psychiatric Study of Adolescents (recently renamed the Association for Professionals in Services for Adolescents) was established in 1969, but the term 'adolescent' was not included in the title of the Royal College of Psychiatrists' Child Psychiatry Specialist Section until 1979. In the US, the American Society for Adolescent Psychiatry was founded in 1967 and, in 1987, the Academy of Child Psychiatry (formed in 1953) was renamed to include adolescents. The history of adolescent psychiatry as a quasi-separate branch of psychiatry, therefore, goes back at most 30 years. It would be misleading, nevertheless, to regard this as the full extent of the subject's heritage, because mental diseases arising in adolescence and youth have been managed within medicine for centuries, although foundations were not laid systematically until the last quarter of the 19th century.

Present position of adolescent psychiatry in the UK

During the last 20 years, research on adolescence has shown that it is not necessarily characterised by emotional upheaval and turmoil, but epidemiological studies have provided clear evidence of significant psychiatric morbidity during the adolescent years (Offer & Schonert-Reichl, 1992). There has been growing world-wide recognition of adolescent disturbance both to the individual and to society, especially conduct disorder, delinquency, drug and alcohol abuse, risk-taking behaviour, suicide and social alienation. Nevertheless, all types of health care services for adolescents have been slow to develop (Friedman, 1985). Even in advanced Western countries, only a small minority of disturbed adolescents is likely to receive specialist assessment and treatment, and many go undetected. In the UK, despite the rapid development of a network of multidisciplinary services, provisions remain variable and incomplete (Health Advisory Service, 1986; Steinberg, 1994). Specialist resources, other than those shared with child psychiatry, tend to be centred on in-patient adolescent units serving large catchment populations. These units have had a reputation for idiosyncratic operational policies and only relatively recently have they begun adopting a more uniform 'general purpose' function.

Standards of postgraduate training in adolescent psychiatry, in conjunction with child psychiatry, have improved substantially under the influence of the Royal College Accreditation Scheme and the Joint Committee on Higher Psychiatric Training. The teaching of medical students about adolescent disorders, however, seems limited. At university level, the academic identity of the subject has become fused with that of child psychiatry, rather than adult psychiatry, and adolescent psychiatry remains without separate professorial representation. This has had considerable implications for the pattern of psychiatric education. The body of scientific knowledge in adolescent psychiatry remains relatively limited and there is a pressing need for research. In general, work with adolescents has not attracted medical students or trainee psychiatrists with interest or training in scientific research, especially in laboratory-based work in the neurosciences. Instead, the appeal has been oriented towards techniques of treatment, with emphasis on the psychodynamic and maturational aspects of practice, comfortably unencumbered by research concerns. This pattern of recruitment will be changed only by vigorous transmission of adolescent psychiatry's broader medical identity and goals (Taylor, 1990).

Rationale for separate adolescent services

Despite clear evidence of enduring psychiatric morbidity, the rationale for separate service provisions for adolescents cannot be taken for granted (Parry-Jones, 1990). For example, although the mental health care provisions for adolescents appear to be underresourced, this does not necessarily constitute a case for the expansion of specialised medical facilities. The prevalence of psychiatric disorder in this age group, with up to 20% suffering disturbance requiring professional intervention, constitutes the principal justification for substantial provision of services. This is especially important in countries undergoing rapid industrialisation, urbanisation and sociocultural change, where disturbance rates are highest. In addition to developmental disturbances of adolescence, many serious mental disorders may have their onset at this time, including schizophrenia, mood disorders, anorexia nervosa, drug and alcohol abuse and personality disorders. Suicide rates in adolescence and youth are rising in many parts of the world, and suicide rivals accidents, malignancy and homicide as the leading cause of death in youth. Such disorders occur in the context of major physical and psychological maturational changes as well as complex adjustments within the family and society. These complicate assessment and diagnosis and require detailed consideration in all forms of intervention, especially psychotherapy. Adolescent psychiatry, therefore, requires thorough familiarity with the phenomena of the normal developmental transitions from childhood to adolescence and on to adulthood. This means that staff need specialised experience and training, which can be best obtained in all-adolescent clinical, consultative, teaching and research centres. Services designed primarily either for children or for adults fail to meet these requirements adequately.

Factors determining future development

Social value attached to adolescence and youth

Adolescent psychiatry is distinguished primarily by the importance attached to adolescent development, its psychological consequences and effects on psychopathology and treatment. Its future is linked inextricably, therefore, with the importance attached by society to adolescence as a distinct developmental period, and to the health, welfare and education of teenagers. This includes the development of laws and policies governing mental health care and, while legislation focusing on adolescents has gathered

momentum, there are still many countries where it is lacking (Paxman & Zuckerman, 1987).

Demographic changes influence these processes. Expected trends suggest increasing ageing of all populations, with wide variation in the proportion aged under 15 years. By the year 2025, for example, children and youth in more developed countries are likely to form 19% of the population. In less developed countries, the numbers will probably continue to rise, although the overall proportion will fall from 37% to 27%; within Africa, 36% of the population will be under 15, while in the UK the proportion will fall to only 9% (Bulatao *et al*, 1990). Despite falling numbers, however, it seems likely that worldwide recognition of the social and economic importance of the mental and physical health of a country's youth is likely to continue to grow. This trend is supported by the fact that as child health measures ensure that most children reach puberty, the quality of adolescent life assumes greater importance and the role of psychological medicine increases correspondingly.

Status of adolescent medicine

Development of adolescent medicine in the UK has been rudimentary, despite many national and international reports and recommendations concerning the special health needs of adolescents (British Paediatric Association, 1985) and growing evidence of the unsuitability of both adult and paediatric settings for hospitalised adolescents (Gillies & Parry-Jones, 1992). Although liaison with paediatrics has played a major part in establishing the role of the speciality of child psychiatry, nothing comparable has occurred in relation to medical practice with adolescents, despite recognition of the potential role of psychological factors in physical disorders and the implications of psychological responses to illness and hospitalisation (Parry-Jones, 1994*b*). This has been related mainly to the absence of designated adolescent specialists among paediatricians, general physicians and surgeons, and also to a tendency for adolescent psychiatrists to distance themselves from mainstream medicine. Both these trends appear to be set to change. Adolescent health-care literature is proliferating (e.g. Friedman *et al*, 1993; Brook, 1993) and adolescent medicine has recently received speciality status in the US.

Definition of clinical boundaries

The predominant emphasis in adolescent psychiatry has been on conduct and emotional disorders, especially those whose causation and treatment is understandable in terms of maturational or family processes. Major morbidity has proved less attractive to multidisciplinary practice, and the adolescent psychoses, for example, have been relatively neglected clinically and academically (Parry-Jones, 1991). This leads on to important questions about where responsibility lies for the optimum management of chronically disturbed older adolescents, for whom, at present, services are lacking almost everywhere. This is despite the urgent need for preventative action to minimise the generation of a 'new chronic' population. Fortunately, a broader view of areas of importance is emerging, reflected, for example, in changing attitudes of senior registrars towards psychosis and mental handicap (Bools & Cottrell, 1990).

Age-range of services

The widely accepted upper age-limit of 16 years fails to acknowledge that skills in adolescent psychiatry may be of benefit to older adolescents and young people. Emotional and behavioural problems associated with transition to adulthood have received relatively little attention and, indeed, may lie outside the familiar practice of adult psychiatrists (Watts *et al*, 1989). Overlap with general adult services is frequently inadequate and unplanned, and the special needs of late-adolescents and young adults may be overlooked. Extension of the age-range, however, would widen the span even further for the child-orientated psychiatrist and emphasise the separate identity of adolescent psychiatry. In turn, this has implications for resource deployment and training, since disorders of older adolescents have more in common with adult disorders than those of childhood (Parry-Jones, 1984).

Investment in prevention and mental health promotion

Adolescent disorders, both those continuing from childhood and those beginning in adolescence, may persist in adulthood and lead to chronic life-long disability. In addition, there is growing recognition of adolescent antecedents of later psychopathology (Robins & Rutter, 1990). The justification, therefore, for early detection and preventive intervention in adolescence is powerful. In addition, present trends suggest that there will be increasing opportunities for innovative preventive programmes and positive mental health promotion, under the aegis of new specialists in 'public health' oriented adolescent psychiatry (Compas, 1993).

Medical and health care education

The teaching of medical students in adolescent medicine and psychiatry is unsatisfactory, and a sustained commitment to education in this field is needed. In this respect, adolescent psychiatry is well placed to lead the way. There is also scope for the inclusion of at least an introduction to the special needs of normal adolescents in the training of all health care providers.

Postgraduate training

All trainees in general psychiatry should be expected to develop a minimum competency in this field, despite the real difficulties in fitting more subspecialist assignments into already overcrowded training schemes. The practice of offering experience in either child or adolescent psychiatry, as if the two fields were interchangeable, is unsatisfactory, because the body of knowledge and skills required is different. Training requirements in adolescent psychiatry, and recommendations for their implementation, receive limited coverage in the guidelines of the Royal College of Psychiatrists (1988) and the Joint Committee on Higher Psychiatric Training (1990), for general and specialist training respectively, and the best presentation of such issues has been by the American Society for Adolescent Psychiatry (Flaherty, 1989). In the UK, it is becoming evident that higher training will have to take into consideration the rapidly changing patterns of service delivery determined by health care purchasers, which could result in the separate provision of child and adolescent psychiatry services. Further complications may follow attempts to harmonise European Community directives with the requirements of specialist training in the UK.

Research

Although the psychology and psychodynamics of adolescence has been a pre-eminent interest, increasing scientific attention is now focusing on the biology of puberty and adolescence (e.g. Bancroft & Reinisch, 1990). However, advantage cannot be taken of these advances, and developments in neurobiology, psychopharmacology, brain-imaging, molecular genetics and epidemiology will be slow to influence adolescent psychiatry, unless more research-oriented psychiatrists are urgently recruited into the adolescent field.

Evaluation and marketing of adolescent psychiatry

Many adolescent psychiatry practices appear relatively unproductive in relation to the corresponding financial investment, and there has been a lack of systematic evaluation of different therapeutic interventions, their costing and economic benefits. In an increasingly cost-conscious health service, and in the face of competition from non-medical disciplines, adolescent psychiatrists must acquire skills in health services research and audit, and begin to demonstrate that existing policies are efficient, let alone justify proposals for future policies. Moreover, in view of the image problem of adolescent psychiatry, its practitioners need to learn to market what they do more effectively and more assertively (Parry-Jones, 1992). The prevailing climate of audit, needs-assessment, cost-containment and competition for contracts has already stimulated these trends.

Recognition of adolescent psychiatry as a speciality

The current standing of adolescent psychiatry in terms of its status as a speciality or sub-speciality is unclear. It shares the clinical and academic stage with child psychiatry, albeit uneasily, and its overlap and common interests with general psychiatry vary. The creation of another speciality, with all its boundary delineation and the bureaucracy involved in conferring credentials, may not be entirely desirable at this juncture, provided that the adolescent component in both general and child psychiatry, can be refined and strengthened, and supported by active specialist societies and journals. It is still too early, however, to gauge the likelihood of such developments, or of the emergence of a sufficiently distinctive body of knowledge and practice to warrant secession. Despite negative aspects, such as the possibility of fragmentation (Yager, 1989), there is already a strong trend in psychiatry towards subspecialisation, driven by the linear phenomenon of advances in knowledge and technology. The boundaries of medical specialities are continually shifting, and there should not be ambivalence about the advent of new specialities such as adolescent psychiatry.

Predictions

Crystal-ball gazing is hazardous, but nevertheless it is interesting to attempt some medium-term predictions, by extrapolating trends based on the factors already outlined. Unless unexpected discoveries redirect the aetiological and therapeutic

focus on to adolescence (and there is some reason to foresee such a trend), all the factors that bear on the likely or possible future development of adolescent psychiatry are known. Of necessity, predictions refer largely to Western adolescent psychiatry, since fiscal pressures in developing countries will continue to restrict their health budgets severely in the foreseeable future.

Sufficient serious morbidity arises in the adolescent years, even within the four to five year span covered by most current services, to warrant continuing, and probably expanding, psychiatric work with teenagers, especially in industrialised countries and in societies undergoing rapid change, as in central and eastern Europe. Interest in detecting and responding to the developmental needs of sick adolescents will increase within general hospital practice, with growing acceptance of the pervasive importance of the psychological and psychiatric component throughout the medical care of young people. This will extend the exposure of adolescent psychiatrists to physicians in other specialities, and both establish and consolidate consultative approaches (Steinberg, 1994). In addition, it will further encourage eclecticism and the re-medicalisation of adolescent psychiatry, counteracting the predominantly psychodynamic–psychosocial orientation and the multidisciplinary ideology which has characterised the subject. In the face of huge efforts to contain costs, adolescent psychiatrists will eventually respond positively to growing expectations of consumers and purchasers for efficient, efficacious services for seriously mentally ill, developmentally disabled and maladapted young people. The demand for empirically validated psychotherapy services will continue to increase, and the spectrum of patients presenting for treatment will widen to include, for example, rising numbers of teenagers with HIV infection. Greater involvement of adolescent psychiatrists in public health policymaking will occur in relation to such issues as drug and alcohol abuse, suicide, violence, sexually transmitted diseases, teenage pregnancy, risk-taking behaviours and the effects of poverty and unemployment. Workload expansion will be accelerated by extension of the age-range to incorporate 18–20-year-olds. This may be the critical factor in the consolidation of speciality status for adolescent psychiatry, although under these circumstances 'youth psychiatry' perhaps, would be a more fitting title. Manpower needs will continue to rise despite the pressures for cost-containment, and there will be a redirection of resources. Educational and training programmes will be expanded. In research terms, rapidly growing interest and progress in the neurosciences will influence adolescent psychiatry, especially in relation to the role of the biological changes of puberty in causing psychiatric disorder. There will be significant advances in psychopharmacology and developmental pharmacokinetics. Despite increasing knowledge of the biogenetic basis of mental disorders, however, exploration of normal maturation will continue to be crucial, with efforts to understand and respond to compromised development. Expanding sociobiological research will generate new interest in, and understanding of, the pathogenesis of adolescent disorders such as depression, especially during the transition to adult life. Overall, the assembly of a distinctive structured body of knowledge will challenge the application of narrow explanatory theories.

In such ways, psychiatric practice with adolescents in developed nations could have an increasingly secure and vigorous future, with enhanced academic influence. Nevertheless, this leaves the question of how far, in practice, it will achieve a truly distinctive and enduring place within psychiatry and medicine into the 21st century. This is particularly difficult to forecast, because it depends on such variables as the calibre of recruitment into psychiatry and the pace and acceptance of subspecialisation, as well as on social, political and economic issues which may encourage or retard change. Above all, it depends on whether existing and future adolescent psychiatrists have the will and capacity to expand research and teaching and to develop models for adolescent and youth mental health care programmes which will be demonstrably effective and have widespread application under different cultural and socio-economic conditions, especially in developing countries. Like the rest of psychiatry, adolescent psychiatry is still in a pre-paradigmatic state (Kuhn, 1962) and this has to be recognised and accepted if progress is to continue successfully.

References

BANCROFT, J. & REINISCH, J. M. (1990) *Adolescence and Puberty*. Oxford: Oxford University Press.

BOOLS, C. & COTTRELL, D. (1990) Future child and adolescent psychiatrists: a further survey of senior registrar training. *Psychiatric Bulletin*, **14**, 611–615.

BRITISH PAEDIATRIC ASSOCIATION (1985) *Report of the Working Party on the Needs and Care of Adolescents*. London: BPA.

BROOK, C. G. D. (1993) *The Practice of Medicine in Adolescence*. Sevenoaks: Edward Arnold.

BULATAO, R. A., BOS, E., STEPHENS, P. W., *et al* (1990) *World Population Projections 1989–90 edn*. Baltimore: Johns Hopkins University Press.

COMPAS, B. E. (1993) Promoting positive mental health during adolescence. In *Promoting the Health of Adolescents. New Directions for the Twenty-first Century* (eds S. G. Millstein, A. C. Petersen & E. O. Nightingale), pp. 159–179. New York: Oxford University Press.

EARLS, F. & EISENBERG, L. (1991) International perspectives in child psychiatry. In *Child and Adolescent Psychiatry* (ed. M. Lewis), pp. 1189–1196. Baltimore: Williams and Wilkins.

FLAHERTY, L. T. (1989) A model curriculum for teaching adolescent psychiatry. In *Adolescent Psychiatry: Developmental and Clinical Studies* (ed. S. C. Feinstein), pp. 491–520. Chicago: University of Chicago Press.

FRIEDMAN, H. L. (1985) The health of adolescents and youth: a global overview. *World Health Statistics Quarterly*, **38**, 256–266.

FRIEDMAN, S. B., FISHER, M. & SCHONBERG, S. K. (1992) *Comprehensive Adolescent Health Care*. St Louis: Quality Medical Publishing.

GILLIES, M. L. & PARRY-JONES, W. Ll. (1992) Suitability of the paediatric setting for hospitalised adolescents. *Archives of Disease in Childhood*, **67**, 1506–1509.

HEALTH ADVISORY SERVICE (1986) *Bridges over Troubled Waters*. London: DHSS.

JOINT COMMITTEE ON HIGHER PSYCHIATRIC TRAINING (1990) *Handbook*. London: Royal College of Psychiatrists.

KUHN, T. S. (1962) *The Structure of Scientific Revolution*. Chicago: University of Chicago Press.

OFFER, D. & SCHONERT-REICHL, K. A. (1992) Debunking the myths of adolescence: findings from recent research. *Journal of the American Academy of Child and Adolescent Psychiatry*, **31**, 1003–1014.

PARRY-JONES, W. Ll. (1984) Adolescent psychiatry in Britain: a personal view of its development and present position. *Bulletin of the Royal College of Psychiatrists*, **8**, 230–233.

—— (1990) Adolescent psychiatric services: development and expansion. In *Child and Adolescent Psychiatry: Into the 1990s*. Occasional paper OP8 (eds J. H. Hendriks & M. Black), pp. 83–89. London: Royal College of Psychiatrists.

—— (1991) Adolescent psychoses: treatment and service provision. *Archives of Disease in Childhood*, **66**, 1459–1462.

—— (1992) Management in the National Health Service in relation to children and the provision of child psychiatric services. *ACPP Newsletter*, **14**, 3–9.

—— (1994*a*) History of child and adolescent psychiatry. In *Child and Adolescent Psychiatry: Modern Approaches* (3rd edn) (eds M. Rutter, E. Taylor & L. Hersov), pp. 794–812. Oxford: Blackwell Scientific.

—— (1994*b*) Psychological and psychiatric aspects of adolescence. *International Child Health*, **5**, 23–31.

PAXMAN, J. M. & ZUCKERMAN, R. J. (1987) *Laws and Policies Affecting Adolescent Health*. Geneva: WHO.

ROBINS, L. & RUTTER, M. (eds) (1990) *Straight and Devious Pathways from Childhood to Adulthood*. Cambridge: Cambridge University Press.

ROYAL COLLEGE OF PSYCHIATRISTS (1976) Memorandum on the psychiatry of adolescence. *News and Notes*, September, pp. 6–9.

—— (1988) Guidelines for the training of general psychiatrists in child and adolescent psychiatry. *Bulletin of the Royal College of Psychiatrists*, **12**, 391–392.

STEINBERG, D. (1994) Adolescent services. In *Child and Adolescent Psychiatry: Modern Approaches* (3rd edn) (eds M. Rutter, E. Taylor & L. Hersov), pp. 1006–1022. Oxford: Blackwell Scientific.

TAYLOR, D. C. (1990) What are physicians doing in child and adolescent psychiatry? In *Child and Adolescent Psychiatry: Into the 1990s*. Occasional paper OP8 (eds J. H. Hendriks & M. Black), pp. 19–22. London: Royal College of Psychiatrists.

YAGER, J. (1989) Subspecialisation in psychiatry. In *The Future of Psychiatry as a Medical Specialty* (ed. J. Yager), pp. 33–46. Washington, DC: American Psychiatric Press.

WATTS, E.L., JENKINS, M. E. & RICHARDSON, G. J. R. (1989) Who cares for the older adolescent? *Psychiatric Bulletin*, **13**, 345–346.

WORLD HEALTH ORGANIZATION (1965) *Health Problems of Adolescence: Report of a WHO Expert Committee*. WHO Technical Report Series No. 308. Geneva: WHO.

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