Forgotten Teenagers

Adolescents are fast becoming the poorest relations among the already underprivileged family of psychiatric patients. Their apparent low priority, which has obvious implications for their healthy future life, is examined by Giustina Ryan and John Payne.

Almost 7,500 young people (between the ages of 10 and 20) were admitted to mental illness hospitals in 1966—the last year for which figures are available. On the face of it the figure may not seem very large when compared with the total population of this age group (6,976,400) but it is a disturbing number simply because there are nothing like enough suitable facilities available for the treatment of these young patients.

The younger ones in the 10-20 age group can go into special units and wards for mentally ill children although such facilities are rare. The eighteen and nineteen year-olds can be successfully integrated into adult wards in psychiatric hospitals although a great many informal patients in this age group are swift to discharge themselves after brief experience of a general adult ward.

For the majority of adolescents, special provisions are needed—the special units which, in 1964, the Ministry of Health recommended Regional Hospital Boards to establish. In that year the Ministry’s Standing Mental Health Committee suggested a minimum provision for adolescents in special units of 20-25 places per million population.

At the time of the recommendation seven of the fifteen Regional Hospital Boards already had opened such units with a total of 180 beds available throughout England and Wales. It was hoped that the provision of places would grow quickly. This has not happened. At the end of 1969 there were still only 10 hospital regions providing units with a total of 318 beds—and there were also some beds in mixed children’s and adolescent’s units.

According to the recommendation made by the then Ministry of Health, the provisions in England and Wales ought to be as shown in the table on p. 6.

These figures are as up-to-date as possible. They have been collected from information requested direct from the Regional Hospital Boards, gaps left by the information not being provided have been filled by figures supplied by the Department of Health and Social Security.

In some cases there are slight discrepancies between the Department’s figures and those of the
| Region                | Population (Millions) 1968 | Beds required (rounded figures) 20-25 per m. | Beds available in 1969 |
|-----------------------|---------------------------|---------------------------------------------|------------------------|
| Newcastle             | 3.09                      | 62-77                                       | 6                      |
| Leeds                 | 3.19                      | 64-79                                       | 44                     |
| Sheffield             | 4.62                      | 92-115                                      | 35                     |
| East Anglia           | 1.71                      | 34-43                                       | 10                     |
| North West Met.       | 4.19                      | 84-105                                      | 30                     |
| North East Met.       | 3.39                      | 68-85                                       | nil                    |
| South East Met.       | 3.53                      | 71-88                                       | 23                     |
| South West Met.       | 3.25                      | 65-81                                       | 48                     |
| Wessex                | 1.96                      | 39-49                                       | 30                     |
| Oxford                | 1.90                      | 38-47                                       | nil                    |
| South Western         | 3.09                      | 62-77                                       | nil                    |
| Welsh                 | 2.72                      | 54-68                                       | nil                    |
| Birmingham            | 5.08                      | 102-127                                     | 42                     |
| Manchester            | 4.55                      | 91-114                                      | nil                    |
| Liverpool             | 2.25                      | 45-56                                       | 18                     |
| Total: England & Wales| 48.52                     | 970-1,212                                   | 32*                    |

* These additional 32 beds are in the psychiatric teaching hospital, Bethlem Royal, and patients are referred to them from all over the country.

There are also 15-20 places available in the Oxford Region in a children's and adolescents' unit and in temporary accommodation. A few places are available in a similar combined unit in the Newcastle Region.

Regional Board but they do not affect the conclusions. The gap between recommendation and reality is so great that any small differences cannot brighten the gloomy picture.

The Ministry's 1964 memorandum had referred to 20-25 beds per million population as the minimum provision required. If the recommendation represents a 'minimum' what is the word for the actual present provisions—'inadequate', 'scanty', 'meagre', 'pitiful'? The chronic scarcity of facilities means that many highly disturbed adolescents are denied the proper form of care, to the despair of their families and the professional mental health workers who attempt to help them.

Ideally, psychiatrists would like to recommend to the courts that many disturbed young offenders should be referred to specialised adolescent treatment units but the likelihood is that one will not exist in the area, or, if one does, the waiting list for admission will be bulging already. Some psychiatrists readily admit that they have stopped recommending placement in adolescent units because it is a waste of time to go through the motions when the effort is bound to come to nothing.

The result is that psychiatrists reluctantly have to settle for second-best or makeshift facilities for disturbed adolescents—too often this means approved school because there is just no alternative. It has been estimated that a third of the children and adolescents in approved schools are in need of sustained psychiatric treatment to correct serious maladjustment or mental illness.

One unfortunate result of not bothering to refer adolescents to special units because the psychiatrists...
trist knows he is ‘flogging a dead horse’ is that the demand for places appears to level out, or even fall, so a Regional Board may be able to say, ‘It isn’t a problem in our area—there’s no demand’ whereas, in fact, the adolescents in need of treatment are languishing in totally unsatisfactory conditions. Disturbed adolescents probably get little or no therapeutic benefit when in the wrong environment and staff in hospitals or approved schools who accept them, knowing they are providing second-best facilities, may find their presence distressing or disruptive.

A particularly serious long-term effect of the paucity of provisions is that the very shortage of facilities makes it extremely difficult for staff to specialise in the treatment of adolescents because the opportunities for training ‘on the job’ are few and far between. Recently a purpose-built unit in the South East Metropolitan area was unable to open because no experienced psychiatrist could be found to take charge of it.

Lack of facilities creates a vicious circle which is likely to perpetuate the existing shortage and the majority of those thousands of young mentally ill people will be the losers. The case of poor little Mary Bell briefly publicised the shortage; it will be a damning indictment of hospital spending if the adult mental health of today’s children and teenagers continues to be jeopardised for the lack of ‘a stitch in time’.

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**Robert & Don**

**Robert** is 16, he has a genetic disorder which results in tallness and mal-formed testicles—he will be sterile. His disorder is associated with immature behaviour and below average intelligence.

His parents are both forty. They were forced to marry very young when his mother became pregnant. The marriage has been unhappy. He has a 22-year-old sister who may be of low I.Q. She had an illegitimate child in 1965. A mentally handicapped elder brother died of chest disease when four years old. His mother is frequently ill, often in hospital and can be hypochondriacal.

His father does social work for the handicapped and unmarried mothers and runs a boys’ club. Robert is fascinated by illness and likes the attention of doctors, when he was 8 he was overjoyed after being circumcised, bouncing up and down in bed saying, ‘I’ve been doctored’. He refers to his mother as a ‘cripple’ and is preoccupied with his own health and body.

Robert began getting into trouble because of petty theft from the age of nine. In 1965 there was a sudden deterioration in his behaviour linked with jealousy of his sister’s baby. He stole, lied, had outbursts of temper, wandered away from home and was prone to anxiety spells. He was sent to a school for the maladjusted until 1968 where he showed delinquent behaviour and made no improvement.

During 1968 he was put on probation for breaking into a gas meter, setting fire to carpets and office breaking. At this time he was seen by a psychiatrist attached to an adolescent unit in Kent. He was considered to be extremely disturbed but was not admitted.

His last charge, in early 1969, was attempted arson—he pushed a piece of paraffin soaked paper through the letter box of the flat below the one belonging to his parents and then tried to drop lighted matches on to it.

The psychiatrist who prepared a report on Robert for his appearance in juvenile court after the attempted arson charge said that he needed psychiatric help in a controlled environment but also needed encouragement and training. He recommended an approved school—with psychiatric oversight rather than the usual infrequent consultations—or an adolescent psychiatric unit. In the absence of either of these facilities the magistrates were obliged to return the boy to his home with the direction that his probation officer should try to find a suitable unit for him. To date, she is still trying.

**Don** is almost 17. His mother, an Italian, married a British liberator and returned to England with him at the end of the war. The marriage was unhappy and, in 1961, Don’s mother obtained a separation order on the grounds of desertion and failure to maintain.

His mother was extremely bitter about the desertion and transferred her bitterness, at least partially, to her son. She became grossly over-protective towards him and, until Don was taken into care in 1965, they slept in the same room. She used her son to replace her husband and vacillated between periods of smothering affection and total rejection of him. The boy was never sure of his emotional stability.

Don reacted to this by alternatively behaving badly and then returning home to test the atmosphere. From the age of eleven he began a career of petty larceny and taking and driving away cars. From 1965 onwards he passed through a local authority children’s home to a school for the maladjusted from which he repeatedly absconded until he was finally referred to an approved school with the proviso that he needed active psychiatric help.

At the approved school the headmaster noted
Don's aggressive spells and his masochistic behaviour. His class teacher was concerned about his immaturity and his liking for childish pranks. Active psychiatric help was not available at the school since the consultant psychiatrist visited only once a week.

The consultant psychiatrist at the approved school agreed with the original recommendation that Don needed close psychiatric supervision which could not be provided in the school. She found him to be a compulsive thief and, in the absence of complete personal supervision, unable to settle to anything. She considered him to be emotionally shallow, lacking in any sense of guilt, very disruptive in any group and too frequently aggressive to others—using anything that came to hand as an implement. She wrote to the senior medical officer in Don's hospital area asking for his transfer to an adolescent unit but was told that there was no suitable unit in the area and that possible units in other areas had long waiting lists.

Don's behaviour deteriorated while at the approved school. After his release in late 1968 he repeated his usual pattern of offences—larceny and taking and driving away—and was returned to approved school early in 1969. He showed a proneness to epilepsy and, because of this and his disturbing effect on the other children in the school, he was released and, with no alternative care available, sent back home.

Since he has been back at home Don has tried three jobs and is getting on a little better with his mother. The psychiatrist who saw Don after his offences to prepare a report for the juvenile court still thinks that he needs more formal psychiatric/neurological assessment as well as help. He is still convinced that every effort should be made to place Don in an adolescent unit. Don himself would be quite willing to go into such a unit—if one were available.

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Tolerating stress

A certain amount of stress is an essential stimulation towards achieving success and harmony in our work and social lives. Dr. Terry Coates, senior medical officer for the Reed Group, looks at the consequences of too much stress in an industrial setting.

Human beings are unhappy and may become ill when working in extremes of temperature, humidity, sound, light, etc. In other words, the physical factors of our environment must be within a given range for the individual to survive and within a more limited range (which may vary from one person to another and with time) for the individual to live and work in comfort. Scales of comfortable air temperature, air movement, lighting and sound levels have been published which enable the factory architect and machine designer to create optimum working conditions in factories and offices.

Studies of human anatomy, physiology and psychology equip the designer to plan a machine built to encompass the functional, structural and behavioural capabilities of the machine operator. Hitherto, the important criteria in machine design have been the basic cost of the machine and the characteristics of raw material and end product. All too often this has resulted in cumbersome machines, uncomfortable—if not dangerous—to control and tiring to operate. The scientific approach to man at work (called ergonomics in this country and human engineering in the U.S.A.) is slowly improving the working environment and hence increasing productivity throughout industry and commerce.

But just as the physical atmosphere can be pleasant or unpleasant to work in, so the psychological atmosphere has its optimal level for satisfying work. It is unfortunate that there is no objective way of recording the intensity of stress to which a person is exposed nor can we prescribe a maximal level to which an individual should be subjected.

Although it is generally accepted that peptic ulcers, high blood pressure, coronary thrombosis, asthma, thyroid gland over-activity and some skin diseases may be aggravated, if not caused, by stressful situations, the effects of prolonged severe mental stress in industry is not clearly understood. For example, it is widely believed that senior executives suffer a higher incidence of coronary thrombosis than the general population. Recent work in the United States has shown that this is