

EDITORIAL

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**Adolescent psychiatry:
its potential to reduce the burden of mental disorder**

The burden of illness in adolescence and young adulthood has shifted greatly in the post-war years. Mortality rates have dropped to historically low levels in most Western countries as new medical treatments and improved standards of nutrition and housing have minimised the occurrence and impact of acute infectious illnesses. Similarly, the introduction of treatments for serious non-infectious childhood onset illnesses, such as cystic fibrosis and childhood malignancy, has brought prospects of survival into adulthood for a range of conditions where previously death in childhood or adolescence was usual. As a result, adolescents have come to be viewed as having good health and relatively few specific needs in health service provision.

Until recently, perceived needs for service provision for adolescent mental disorders have been similar. Emotional difficulties were, in the past, commonly ascribed to psychological and social pressures intrinsic to normal adolescent development. An absence of evidence for adverse effects on later emotional well-being or social adjustment brought ambivalent attitudes to clinical intervention and adolescents with mental disorders, by and large, received little coordinated provision of services. The emotional and behavioural problems of younger adolescents were commonly dealt with in settings of child guidance or child psychiatric clinics in general hospitals. Severe mental disorders in older adolescents were often dealt with in asylum or general hospital settings, most poorly suited to the needs of adolescents and their families. The few specialist adolescent services available in most countries largely retained an in-patient focus with an emphasis on treating severe behavioural disturbances. Opportunities for intervention with commoner but less severe distur-

bances were limited by the availability and accessibility of services.

Epidemiological studies have, over the past 25 years, slowly shifted perceptions of service need for adolescent mental disorders. The Isle of Wight and inner city studies by Rutter and colleagues did much to change prevalent views that emotional upheaval was usual in adolescence [1]. Far from turmoil, a majority of young people negotiate the adjustments that follow puberty without great disruption. Nevertheless, these and subsequent surveys demonstrated that psychiatric disorders are common in school-age children, with around 15% meeting criteria for caseness [2]. Moreover, distinct shifts in the pattern of disorders and problem behaviours occur post puberty. Depressive symptoms become more prevalent, different manifestations of anxiety emerge and behavioural disturbances, such as eating disorders, substance abuse and suicidal behaviours, uncommon in childhood, rise in frequency. Recent studies of the onset of psychiatric disorders in adults have heightened this growing interest in adolescent mental disorders with reports that hazard rates for the onset of common disorders, such as depression and substance abuse, appear to be highest in the teens and early twenties [3]. These parallel paths of investigation in adolescent and adult populations have done much to confirm the considerable burden of illness associated with adolescent mental disorders and have in turn raised questions about the potential for early and preventive intervention. This important series of papers draws together recent epidemiological and clinical evidence to explore further this knowledge base of adolescent psychiatry.

A number of prospective epidemiological studies in both clinical and non-clinical settings have now described the natural history and adverse consequences of adolescent mental disorders. Among the most important studies have been population-based cohorts such as the Christchurch and Dunedin studies in New Zealand. In the first paper in this special edition, David Fergusson draws on this evidence to address continuities and discontinuities over time in externalising problems [4]. This group of problems, which includes conduct and attention deficit

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disorders, commonly presents to clinicians during the teen years as a result of offending, school failure, substance abuse or behavioural disturbances. The evidence for continuity in externalising problems between childhood, adolescence and adulthood is strong, particularly when due consideration is given to the problem of measurement error, a common source of artefactual change in longitudinal studies of mental disorders. The strength of continuities from early childhood support primary preventive interventions targeting risk processes in a younger age group. However, these studies also provide a framework for intervention with adolescents. Typically, there is a developmental progression in externalising disorders where earlier behavioural problems within the family are later complicated by school problems and educational underachievement, affiliation with more deviant peers, giving rise in turn to an increasingly elaborate pattern of antisocial and health risk behaviours. The focus of intervention in adolescence remains preventive with the aims of minimising further elaboration of this developmental sequence. Given the complexity of developmental and social factors underpinning externalising disorders, effective intervention is likely to be multi-faceted involving family, school, peers as well as individual treatments. Fergusson suggests that an understanding of turning points, developmental transitions such as marriage or leaving school which close down or open up opportunities, is particularly relevant to effective adolescent and young adult intervention.

Behavioural changes following shifts in the lifestyles of adolescents and young adults have been a second focus in recent re-assessments of adolescent health need. Downward age trends have been reported in tobacco use, sexual activity, alcohol and illicit substance use, where concerns about persistence of health damaging lifestyles into adulthood have brought an emphasis on prevention in adolescent health care [5]. Eric Fombonne describes the growing burden of illness associated with adolescent mental disorders as a result of secular trends in onset and then considers the implications for adolescent health service provision [6]. Measurement biases due to subject recall, change in service provision or case definition confound easy interpretation of this body of evidence. Data from serial surveys have confirmed a recent rise in adolescent depressive symptoms albeit of modest extent. For externalising problems and substance abuse, trends towards higher adolescent prevalence are clear, but for other problems, such as eating disorders, the absence of adequate surveillance data leaves the extent of change uncertain. Even so, the evidence is sufficient to indicate a probable increase in future demand for adolescent psychiatric services, as well as indicate changes in the type of problems presenting and the training requirements for mental health professionals working with adolescents.

Depression is the commonest major mental disorder in adolescence. As a forerunner of later disorder in adulthood, suicidal behaviour, educational failure and unemployment its costs to health services and individuals are great. Recent pressures to adopt a more comprehensive

service response to reduce the burden of illness are therefore understandable. Richard Harrington and Andrew Clark consider the scope for preventive and clinical intervention. They outline examples of universal, selective and early intervention for adolescent depression, but point out that data on effectiveness are currently limited. In contrast, there is growing evidence for the effectiveness of clinical interventions in treating depressive episodes and encouraging findings for their efficacy in preventing relapse in the short term. In this light the authors raise an important question about the relative emphasis that should be given to the implementation of clinical interventions of proven efficacy as opposed to preventive interventions where as yet neither efficacy nor potential for harm have been adequately evaluated. Answers to this question are likely to do much to shape the future of adolescent psychiatry.

Systematic nineteenth century studies of the inmates of asylums documented that many cases of mental disorder had an onset before the age of 20 years. Recent clinical epidemiological studies have taken this work on early-onset psychosis further and been at the forefront of defining health needs and intervention strategies in early schizophrenia. The importance of treatment delays in predicting clinical outcome schizophrenia has long been recognised in disorders where clinical outcomes in the short term strongly predict eventual outcome. More surprising has been the extent of delays in treatment reported in many countries, delays which have focussed the efforts of treatment services on achieving reductions in the duration of untreated psychosis. Patrick McGorry outlines the current state of knowledge on intervention for early-onset psychosis [7]. The evidence base from randomised trials is again limited. Nevertheless, studies using historical controls suggest that the introduction of specific treatment programs tailored to the needs of younger patients brings not only improved short-term clinical outcomes but a greater cost effectiveness through minimisation of the need for extended hospital admission. He describes two further strands of early intervention work in psychotic disorders; one focuses on the prevention of relapse and minimisation of residual symptoms and impairments, and the other concerns intervention prior to the onset of full-blown psychosis and is informed by studies such as those of Häfner and colleagues in Mannheim, Germany, who described long prodromal periods preceding florid psychosis with many of the earliest clinical manifestations of psychosis occurring in adolescence and young adulthood [8]. McGorry describes recent successes in identifying a group of young people at very high risk for psychosis, where around 40% made a transition to psychosis within 12 months. Such a finding raises a possibility that interventions to prevent or delay the onset of psychotic illnesses may be possible in some groups.

This series of papers describes the great recent progress made in delineating the burden of illness associated with adolescent mental disorders and the potential for intervention. Some tentative predictions on the future of adolescent psychiatry seem possible. As a field it is shift-

ing from a narrow focus on a small group of adolescents with severe and persistent disruptive behaviour to one concerned with the scope for preventing disability associated with many of the most severe and common psychiatric disorders. As yet, adequate answers to questions of the relative efficacy and cost-effectiveness of treatments and preventive interventions are not available. Nor yet is there evidence that intervention for adolescent mental disorders reduces psychopathology and disability in the longer term. As this knowledge base grows, so too might we expect the potential of adolescent psychiatry to reduce the burden of illness associated with mental disorders to be realised.

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