Court's committee[2] or the WHO[3]), but his suggestions, though low key, deserve serious attention from politicians as well as academics.

The frequency of adolescent disorders depends, he says, on four variables, each of which is amenable to intervention. Firstly, individual predisposition is affected by genetic influences and the environment in which the child is brought up. Counselling and psychotherapy have proved disappointing in countering such disadvantages, and Rutter's conclusion is that priority must be given to prevention: preventing unwanted births, especially to teenage and single women, by expanding family planning programmes, and reducing the frequency of organic brain dysfunction by improving the obstetric and neonatal paediatric services. Continuity of good quality parenting is another vital factor—and he is quite specific on this point: "in the case of young children whose parents seem unlikely ever to be able to look after them at all adequately, an *early* decision should be taken with respect to adoption or long term fostering." And all teenagers, he believes, should be encouraged to learn about caring by helping to look after younger children, the sick and lonely, and old people.

The second variable is the social environment, and in particular schools and housing. Again Rutter speaks plainly: a selective system of schooling may well have advantages for the 15% of children in the academic élite, but it almost certainly has great disadvantages for the 85% of children in the non-academic schools. The outcome for pupils is known to be worse, and delinquency more frequent, in schools with a high proportion of intellectually less able children. Ideally every school should have a balance of abilities close to the national average among its intake: unfortunately no easy way has yet been found to achieve this. In the long run, Rutter suggests, the solution may be to ensure that communities are sufficiently socially mixed so that community schools would get this ideal reasonable balance of intakes. Such a pattern would also help to reduce the stresses on children of being brought up in areas with above-average densities of disadvantaged families.

Thirdly, some of the deviant behaviour of adolescence could be prevented by specific interventions. Rutter lists making alcohol less readily available by raising its price and restricting licensing hours; persuading doctors to reduce levels of prescribing to lessen the availability of drugs for self-poisoning; making more use of school premises for leisure activities; and improving standards of maintenance of public buildings—a proved method of reducing the frequency of vandalism.

Fourthly, adolescent behaviour is amenable to influence by the health services for children—if their quality is good enough. Here Rutter echoes a theme familiar to *BMJ* readers: "those clinicians engaged in therapeutic services should include a good proportion of the more experienced . . . it cannot be right that a profession [nursing] whose raison d'être is personal care should heavily penalise those individuals who wish to continue in the work for which they were trained . . . Much the same issues apply to social work." Adolescents ought, he says, to be able to refer themselves for help, and opportunities for consultation should be available wherever teenagers work and meet.

Is this degree of concern with teenage problems justified, sceptics may ask, especially at a time of economies in public spending? Professor Rutter quotes consistent evidence that serious personal, psychiatric, and psychosocial troubles are more frequent in adults whose behaviour was persistently antisocial during adolescence. Thus intervention is warranted, with effective monitoring of its outcome—and the same is true of the response of the penal system to adolescent offenders. No one grand strategy will provide all the answers: a variety of treatment methods and social policies need to be tried and assessed. Rutter's final, and sobering, thought is that more has not been done already largely because of the resistance to change attributable to professional self-interest, political dogma, and financial constraints.

[1] Rutter, Michael, *Changing Youth in a Changing Society*. The Rock Carling Fellowship 1979. London, Nuffield Provincial Hospitals Trust, 1979, £7·50.
[2] DHSS, *Fit for the Future*. Report of the Committee on Child Health Services (chairman S D M Court). London, HMSO, 1976.
[3] World Health Organisation, *Child Mental Health and Psychosocial Development:* report of a WHO Expert Committee. WHO Technical Report Series no 613. Geneva, World Health Organisation, 1977.

Mass eating

One of the most devastating replies to a bedside inquiry after the wellbeing of a patient is, "When I get home and get some good food I'll be much better, thank you, doctor." Good food has two meanings, good to eat and good nutritionally, and some institutional meals are neither. Yet with the kinds of food available in the Western world the two are synonymous. It is extremely difficult to select an attractive and palatable menu that does not at the same time supply the nutrients required.

Why, then, if it is so easy to obtain the required nutrients from the wide variety of available foods are there so many complaints about institutional catering—school meals, hospital meals (in both the ward and the dining room) and meals in refectories and canteens? Probably because our wants are so diverse (one man's mince is another man's slop) and because the limitations of facilities and staff and the inevitably severe restrictions of cost call for the highest skills by the caterer—and the call remains unanswered.

The critic's cleaver should not be wielded indiscriminately. Those eating in a few institutions, including some hospitals, boast of the high quality of the food they get, but these appear to be the exceptions. Food is an easy target but too often it is a justified target. The low esteem in which school meals are held may be on a par with mother-in-law jokes, but evaluations have shown most of them to be inadequate in quantity quite apart from the opinion of the school gourmets. Hospital meals are expected to tempt the sick palate, but again all too often they fail objective tests.

We have recently complained[1] that some parts of our hospitals are little cleaner than the worst of our railway stations—a comment that can be linked with a report of food poisoning in hospitals.[2] In a wartime pamphlet[3] a Minister of Health stated "a good kitchen superintendent makes a healthier and happier hospital, and experience has often showed that the better the feeding the less the cost." We have learnt a lot about hygiene, nutrition, and people's wants in the past 40 years but have not applied the knowledge. The consumer does not complain (even the critical school child finally gives up); the doctor is not aware; but does the caterer care?

[1] *British Medical Journal*, 1979, **2**, 952.
[2] Thomas, M, *et al*, *Lancet*, 1977, **1**, 1046.
[3] *War-time Feeding in Hospitals*. London, Ministry of Health, 1942.