CHAPTER 1

A brief history of child and adolescent psychiatry

Dora Black and Simon G. Gowers

The history of the treatment of children's deviant behaviour goes back centuries (Wardle, 1991), but the first child guidance clinic, established in Boston in the early 1920s, continued the focus on delinquent children and marked the beginning of the child guidance movement. This launched the application of 'scientific' methods to the study and treatment of deviant children, and quickly extended to the UK and Europe.

The first child guidance clinic in the UK was founded by the Jewish Health Organisation in the East End of London in 1927. Emanuel Miller, a psychiatrist, was appointed as honorary director together with a psychiatric social worker who had trained in the Boston Clinic, and a psychologist. A year later, the London Child Guidance Centre opened under the direction of Dr William Moody, who had trained at the Maudsley Hospital where children and adolescents had been treated for some years. When Miller moved to the Tavistock Clinic in 1933, a new department for children was established, pioneering the recognition of family influences on child psychopathology, and a focus on the assessment and treatment of the whole family (Hersov, 1986).

Although general psychiatrists had sometimes treated children and adolescents, and some paediatricians had considered the psychological as well as physical aspects of paediatric disorder, it was only after the Second World War that child psychiatry separated as a specialty from general psychiatry. By the late 1940s, child guidance clinics were spreading rapidly and by the time of the establishment of the National Health Service (NHS) in 1948, many local authority districts provided a rudimentary service. By the end of the 1960s, most child psychiatrists in the UK were employed by the NHS and were working in child guidance clinics with social workers, educational psychologists and sometimes child psychotherapists and teachers. The services were usually housed in accommodation owned by the local education authority, which provided administrative services. Occasionally there was joint provision with the NHS, but hospital-based child psychiatric

clinics were still relatively rare. The geographical isolation of the clinics from other health facilities led to the alienation of some child psychiatrists from their roots in medicine and general psychiatry, while educational psychologists were divorced from colleagues in academic and clinical psychology. As social workers were equally separated from their colleagues in local authority departments, there was little cross-fertilisation of ideas and few opportunities for teaching, research or the development of the political expertise to enable effective expansion of services to take place. A shortage of trainees in child psychiatry to challenge established dogma contributed to the entrenchment of outdated and ineffective practices in some clinics. Classification was rudimentary, the aetiology and treatment of most disorders was poorly understood and there had been almost no research on the therapies being used (Black, 1987).

By the 1970s services were developing rapidly, but were rarely based on any assessment of the needs of the community. Kolvin (1973) found that less than 1% of the child population were receiving help from child guidance clinics, yet 7–20% of children were identified as suffering from a definite and functionally disabling psychiatric disorder (Rutter *et al*, 1970). The lack of available therapeutic resources was sometimes exacerbated by a focus on psychoanalytic training, and consequent intensive and lengthy treatment.

Academic departments of child and adolescent psychiatry were established earlier in the USA than in Europe. The first academic department of child psychiatry to open in England in 1972 was led by Professor Michael Rutter at the Maudsley Hospital. However, the growth of academic departments was slow. Kanner's delineation of the new syndrome of infantile autism (Kanner, 1943), Robertson's films on children in hospital (Robertson, 1952, 1958), Bowlby's seminal ideas on attachment and loss (Bowlby, 1969, 1973, 1980), Winnicott's concept of 'good-enough' mothering and his attention to mother–child relationships (Winnicott, 1965), Robin's long-term follow-up of child guidance patients (Robin,1966), Rutter's work on epidemiology (Rutter *et al*, 1970) and Kolvin's careful assessment of treatment strategies (Kolvin *et al*, 1981) are landmarks in the history of child psychiatry.

By the end of the 20th century, most UK medical schools employed academic child and adolescent psychiatrists, while most postgraduate higher training schemes had links to a university department.

The late 20th century also saw a number of developments in therapeutics. Early treatments had been based on psychoanalytic theory and technique, as applied to children by Anna Freud (1928) and Melanie Klein (1932), and play therapy, as described by Lowenfeld (1935), with concurrent guidance for the mother (but rarely the father) by psychiatric social workers. Other treatment approaches such as behaviour therapy (developed mainly by clinical psychologists), family

therapy in its various schools, group therapies and occasionally drug therapies were integrated into eclectic practice in the 1970s and 1980s. Although some services might have specialised in a form of therapy or a type of disorder until the mid-1980s, more comprehensive services subsequently developed. Pharmacotherapy became more widespread as the practice of child and adolescent psychiatry became eclectic and more evidence-based. More recently, cognitive–behavioural therapy, cognitive–analytic therapy, dialectical behaviour therapy and other approaches have been developed, often with a focus on particular patient groups. Many parts of the UK have seen a great expansion of child psychiatric services into the 21st century, and although most of these services have become multidisciplinary, many have seen a withdrawal of social work input. This is despite the establishment in the 1990s of child protection teams and moves towards the joint commissioning of child and adolescent mental health services (CAMHS) by health, education and social services.

The advent of clinical audit in the NHS required all services to measure performance against standards, following the 'purchaser/provider split', to report on these to service commissioners. The establishment of the UK National Institute for Clinical Excellence at the turn of the 21st century heralded the introduction of national treatment guidelines, the first on the use of methylphenidate (National Institute for Clinical Excellence, 2000), to be followed by guidelines on the treatment on childhood eating disorders and depression, in order to standardise clinical practice.

Training for child psychiatry

A famous debate on training took place in the 1960s between Dr Donald Winnicott of Paddington Green Hospital and Professor Aubrey Lewis of the Maudsley Hospital (Lewis, 1963; Winnicott, 1963), with Winnicott advocating the route for training child psychiatrists through paediatrics and Lewis through general psychiatry. Although there is much to be said for child and adolescent psychiatrists having a sound basic training in both disciplines before starting higher training, many now have little or no experience of paediatrics. The Royal College of Psychiatrists requires all higher trainees in child and adolescent psychiatry to have passed the membership examination after training in general psychiatry. By the turn of the 21st century, it was mandatory for all those completing basic training to have had 6 months' experience of either child and adolescent psychiatry or services for children with learning disabilities. Higher training had by this time, however, been reduced from 4 years to 3 years in order to bring postgraduate training into line with the rest of Europe. During higher training, the Royal College of

Psychiatrists has become increasingly prescriptive about training requirements; balancing clinical training with research and the development of a wide range of therapeutic skills. Management experience is also required in a very full training programme, which is formally reviewed at annual intervals to ensure attainment of a Certificate of Completion of Satisfactory Training after 3 years. As the evidence base for the practice of child psychiatry is growing rapidly, clinicians have appreciated the necessity to update skills and knowledge on a regular basis. The necessity for 'life-long learning' is now established, and 21st-century practitioners are required to regularly update personal development plans and submit to annual appraisal within the NHS.

Organisation of services

A series of studies and reports in the 1970s and 1980s (Brunel Institute of Organisation and Social Studies, 1976; Royal College of Psychiatrists, 1978, 1986; Interdisciplinary Standing Committee, 1981) exposed difficulties in the traditional way of organising child guidance services. A perceived lack of clearly defined leadership and a muddled management structure led to intractable problems in some clinics. Some (Graham, 1976; Rutter, 1986) saw positive trends in the practice of child psychiatry – a reflection of the efforts that had been made over the years to maintain good relationships in the multidisciplinary team, although this was often at the expense of efficiency and good practice. By the early 1980s, child psychiatric practice had moved on little from the historical child guidance model based on the disciplines of psychiatry, social work and educational psychology, in a style of practice unsuited to the developing NHS. Modern practice needed to be more flexible, with contributions from the disciplines of clinical psychology, psychiatric nursing, child psychotherapy, teaching, dietetics, occupational therapy, art and music therapies, physiotherapy, paediatrics, general psychiatry, radiology, neurology and others as needed. By the early 1990s, reviews of child and adolescent mental health services consistently reported that services were incomplete and uncoordinated, as well as being patchy across the country (Kurtz *et al*, 1994). Services were criticised on the basis of their failure to meet local need and their exclusion of those who did not meet criteria for the particular treatments offered by the local service. There was often a lack of planning, particularly where liaison between the three statutory agencies (education, health and social services) was required. There was also poor communication with the voluntary sector.

In 1995 the Health Advisory Service proposed a strategic approach to commissioning and delivering a comprehensive CAMHS (Health Advisory Service, 1995). This emphasised a continuum of care, a range

of treatments in a variety of settings (community, day care and residential) and a seamless transition from one level of care to the next. In the UK the Department of Health recommended the adoption of a tiered model of service, in which Tier 1 comprises services delivered in primary care, Tier 2 CAMHS professionals working singly, Tier 3 the multidisciplinary specialist CAMHS, and Tier 4 very specialised out-patient services for children and young people with complex disorders and in-patient care. With the development of NHS trusts, child and adolescent mental health services found themselves in a range of acute, community and mental health organisations. In the early 21st century, a number of these reorganised into specialist mental health or 'partnership' trusts. The private sector became a significant provider of CAMH services for the first time (particularly Tier 4), with NHS commissioners purchasing private services for NHS patients where there were gaps – particularly in the field of eating disorders. The implementation of the Children's National Service Framework (Department of Health, 2004) will see a blueprint for services that can begin to even out inequalities. The Commission for Health Improvement and later the Commission of Health Audit and Inspection were also designed to improve and monitor the quality of services. Although the demands on child psychiatrists are constantly growing, with a greater expectation of their having a role in youth offending teams and the treatment of those with early-onset psychosis, funding for CAMHS has grown and services are now able to provide a more comprehensive range of interventions than ever before in their history.

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