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From Adult Lunatic Asylums to CAMHS Community Care: the Evolution of Specialist Mental Health Care for Children and Adolescents 1948-2018

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l'évolution des services de santé mentale pour les enfants et les adolescents
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Introduction

- ¹ As the psychiatrist William Parry-Jones has pointed out, the development of psychiatry, and the care offered to the mentally ill, has always depended not only on “*the prevalence and severity of cases but on economic, social, political and cultural factors.*”¹ This has led the social historian Martin Gorsky to argue that although mental health services have always been part of the National Health Service (NHS), psychiatric care forms one of three “*subaltern narratives [... which] stand somewhat apart*”² in general histories of the NHS as the way they have evolved is the consequence of very specific issues. I would like to suggest that child and adolescent mental health care is a separate narrative within this subaltern narrative. Its development has resulted not only from changes in policies for adult mental health care, but also from changes in society’s attitudes towards children and parenting, and from a greater biological and psychological understanding of how children develop. Most of the existing scholarly articles on the evolution of child and adolescent mental health care have been written by psychiatrists and focus on the changes in clinical

practice. This article attempts to situate the history of care for young people suffering from psychopathologies³ within a wider social and political context.

Incurable lunacy or transitory developmental problem: the treatment of children with mental health needs before 1948

- 2 Prior to the foundation of the NHS, mental health was the form of health care which received the largest amount of public funding as a result of two acts of parliament dating back to 1845: the *County Asylum Act* and the *Lunacy Act*. These two acts together made counties legally obliged to provide asylums for their lunatics in order to remove the insane from workhouses. There was no minimum age for admittance to these asylums and although many of the asylums were reluctant to admit children, the workhouses were keen to get rid of them, and there are records of children as young as six being admitted and kept on wards alongside adults. The young people admitted to adult asylums were most likely to be suffering either from “*idiocy*” or from “*moral insanity*,”⁴ although Maudsley’s influential 1867 textbook stated that children could also suffer from “*monomania, choleric delirium, cataleptoid insanity, epileptic insanity, mania and melancholia*.”⁵ There were no specific treatments for child and adolescent patients but this was perhaps less problematic than it might seem since the general consensus at the time was that lunatics were exhibiting child-like behaviour and should be treated as children.⁶
- 3 Less seriously disturbed children were treated in child guidance clinics, the first of which was set up in East London in 1927. The aim of these clinics was “*the treatment of children who had emotional problems or nervous difficulties*.”⁷ Unlike the asylums, the clinics were not always publically funded and the first ones to be opened relied on private or charitable donations. Things changed in the mid-1930s when the Board of Education allowed attendance at a child guidance clinic to be counted as school attendance, leading many local authorities to set up and fund their own clinics. The staff at these clinics worked in teams with a psychiatric nurse, a social worker and a psychiatrist. They used medical language – the children who came to see them were “*patients*” and the psychiatrists looked for the “*aetiology*” of the children’s problems; as the historian John Stewart points out, for the first time, childhood was being pathologised,⁸ an attitude which was to re-emerge in NHS policies. Another factor which was to have an impact on later policies was the clinics’ belief that normalcy was a continuum. A child was not born either “*maladjusted*” or “*normal*” and any child’s position on this continuum could change due to different circumstances. The implication of this was that since “*even the most normal child could experience maladjustment, [...] the total child population had to be constantly monitored and surveyed, both by parents and by professionals*,”⁹ in other words, what went on inside the family was no longer a private affair.
- 4 The clinics claimed that early intervention was good for society as a whole, stating that they were “*equally a social service to a sick society as a personal service to children and their parents*.”¹⁰ However, although the clinics recognized that children’s psychological problems were affected by social conditions such as poverty, poor housing and unemployment, they paid more attention to the role of family relationships (particularly family break-ups) on the child. This resulted in the belief that it was not just the child who should be treated but the whole family (although in practice it was usually only the

mother). Although the clinics claimed not to be blaming the parents, they published advice leaflets on how to raise well-adjusted children, which were widely distributed to all parents. It was therefore almost inevitable that those who ended up seeking help from the clinics would feel that they had failed in some way as parents.

- 5 The belief that parents were largely responsible for their child's mental health was challenged by the work of Anna Freud and Melanie Klein in the 1930s who believed that even very young children had their own internal life, and that children could be treated directly with therapy without having to treat the parents at the same time. Like many things in Britain, however, the availability of help for mental health was linked to social class. The type of psychoanalytic-psychotherapy that was practised by Freud and Klein was only available privately and even in the child guidance clinics psychotherapy tended to be reserved for the brightest children and teenagers from middle class families with the aim of helping them (re)adapt to normal life. Children from working-class families, who were diagnosed by doctors as "difficult," were sent away to residential schools in an attempt to prevent them from becoming delinquents.¹¹
- 6 The end of the Second World War brought with it profound changes in the structure of British society and it was inevitable that these changes would influence the treatment of mentally ill adults and children. 1946 saw the first attempt to unify the provision of mental health services for the population as a whole with the foundation of the National Association of Mental Health (NAMH).¹² This was done by merging three existing mental health organisations: the Central Association for Mental Welfare (a voluntary group which helped mentally-handicapped people), the National Council for Mental Hygiene (whose aim was to educate both medical students and the general public about the importance of mental health), and the Child Guidance Council. The NAMH recognised the lasting effect of poor childhood mental health on adult life and stated that its first aim was to "to establish the principle that [good mental health] foundations must be laid in early childhood if healthy mental and emotional development is to be achieved;"¹³ a principle which can be found in all later policy statements about child and adolescent mental health care.
- 7 The 1944 Education Act, (which was implemented only after the Second World War had ended) placed what it termed "maladjusted children" (those with emotional and behavioural problems) into the same category as those with a physical disability. This meant not only that children with mental health problems now came under the remit of school medical services, but also that schools were required to provide them with an education. This paved the way for a wider acceptance of the idea that mentally unwell children could continue to lead a normal life while undergoing treatment within the community.
- 8 The return of thousands of evacuee children, many of whom exhibited serious psychological problems, led to a new academic interest in child development. One of the most significant contributions came from the psychiatrist John Bowlby who proved that attachment stability between a child and its primary care-giver plays a vital role in a child's mental health. This recognition of the importance of the child-mother relationship underlies many later policies; it led, for example, to the development of family therapy as a specific branch of psychotherapy, and became a justification for developing community, rather than institutionalised, care.

The early years: hospital care versus child guidance clinics

- 9 The existence of state-funded asylums, which provided free care for people from all social classes, meant that the advent of the National Health Service was initially less revolutionary for mental health than it was for physical health. There was, however, no attempt to set up a single, unified mental health service for children and adolescents within the newly established NHS despite the growing interest in problems specific to young people. As a result two separate forms of services for children and adolescents were established, in line with a 1946 report by Blacker, entitled *Neurosis and the Mental Health Service*, which recommended that children with mild problems should see a psychologist at a child guidance clinic while those with more severe problems should be treated by a psychiatrist in a hospital setting.¹⁴ His report made no attempt to clearly define which children should see which service, and offered no guidance as to how children might be transferred between clinics and hospitals if their mental health worsened or improved.
- 10 Although no specific sum of money from the NHS budget was allocated either to the clinics or to hospital child psychiatric care, the 1950s saw an increase in the number of child guidance clinics, and by 1955 there were 300 clinics spread throughout England.¹⁵ The development of hospital psychiatric care was patchier. The first hospital ward specifically for mentally ill children had been opened at the Maudsley hospital in July 1939, but closed two months later when the Second World War was declared, and it was not until 1947 that a dedicated children's in-patient unit was re-opened there. During the 1950s most of the NHS teaching hospitals opened specific children's units but outside the larger cities children who needed to be treated by a psychiatrist in a hospital setting continued to be seen alongside adults. By 1964 there were still only seven child and adolescent in-patient units in the whole of England and Wales with a total of just 157 beds.¹⁶
- 11 One of the reasons for the lack of separate child and adolescent in-patient units may have been the lack of recognition that children and adolescents suffer from specific psychiatric problems. The term "child psychiatry" first appeared in a text book title in 1933¹⁷ but child and adolescent psychiatry was not recognised as a specific psychiatric discipline until 1973 when the first Chair of Child Psychiatry was created.¹⁸ Similarly, the widely used American *Diagnostic and Statistical Manual of Mental Disorders (DSM)* did not initially refer specifically to childhood mental health disorders – the only one listed in the *DSM-I*, published in 1952, is "mental deficiency." In 1968, the *DSM-II* listed what it termed childhood "reactions" such as "withdrawing, being overanxious, running away, being unsocialised or aggressive, group delinquency and hyperkinetic." It was not until the third edition, published in 1990, that a comprehensive list of child psychiatric disorders was included.
- 12 Nevertheless, the 1959 *Mental Health Act*, which for the first time sought not only to distinguish mental illness from learning disability, but also to limit the number of people detained against their will, did recognise children as a separate category. Under the terms of this act, adults over the age of twenty-one could only be compulsorily detained in hospital in cases of severe sub-normality or severe mental illness, whereas those under twenty-one could be detained with lesser levels of sub-normality provided they also either showed signs of a "psychopathic disorder," or were a danger to their self or to others.

If it was deemed necessary, parents could be compelled to send their “mentally disordered” children to a residential training centre to enable them to receive some form of schooling and to prepare them for employment. The rights of children aged sixteen to twenty-one, however, remained unclear as the *Mental Health Act* used the same definition of “child” as the 1948 *Children’s Act*. This meant that although minors aged sixteen and above could be detained under the criteria for minors, and their parents ordered to place them in residential care, these minors were deemed capable of making their own decisions about their treatment and could appeal to a tribunal without their parents’ permission.

- 13 Although this act was supposed to limit the number of mentally unwell people in hospitals, and did indeed result in large numbers of adults being discharged, the 1960s saw an increase in the number of child and adolescent beds. As Christopher Wardle points out, this apparent paradox can be explained by the fact that the act had led to an increasing realisation that children needed to be treated separately from adults.¹⁹ The increase in bed numbers was thus not a reflection of an increase in the number of young people receiving in-patient treatment.
- 14 Throughout the 1950s, psychiatrists and paediatricians discussed how the community child guidance clinics and the hospital psychiatric services could be merged to provide a more unified service. Most of the discussion focussed on who should be in charge, rather than on what treatment should be provided, and it proved almost impossible to reach any sort of compromise.²⁰ The staff working in a hospital setting argued that child guidance clinic resources were often wasted because the clinics made no attempt to diagnose their patients, leading to open-ended therapy which seemed to have no clear goal.²¹ The staff working in child guidance clinics, on the other hand, claimed that they were underfunded compared to hospital psychiatry and therefore limited in the treatment they could offer. They also accused hospital psychiatrists of damaging the child by removing them from their family and failing to treat the “whole” child.²²

Towards a specific child and adolescent mental health service

- 15 By the late 1960s it was becoming increasingly clear that this dual system was not working – some places had two overlapping services and others had none. It was not until the mid-1980s, however, that any profound changes were made to the provision of child and adolescent mental health care. The reasons which finally led to a specific policy appear to have stemmed partly from changes in adult psychiatric care, partly from a better understanding of the nature of child and adolescent psychopathologies, and partly from new attitudes towards teenage behaviour.
- 16 In his 1961 “*Water Tower Speech*,” Enoch Powell, the health minister in the Macmillan Conservative government, drew attention to the need to reform the treatment of the mentally ill by closing down the asylums. He believed that the number of places needed in asylums would gradually decrease not only as a result of the 1959 *Mental Health Act* which had enabled patients to appeal their certification, but also because of recent developments in psychiatric medicines which meant it was now possible to control many previously untreatable conditions. Powell questioned the need to keep the mentally ill in separate institutions from the physically ill and suggested that in the future general hospitals should provide beds for both physically and mentally ill patients. There was no

real attempt to turn his ideas into actual policy, however, until Barbara Castle's 1975 white paper, *Better Services for the Mentally Ill*, which proved to be a turning point in mental health services for both adults and young people. The white paper argued that mental illness was not just a hospital problem but also a social issue, and that asylums should eventually be replaced "with a local and better range of facilities."²³ The ultimate aim of this new policy was not to close all asylums – the paper recognised that there would always be some patients who were too unwell to function outside a hospital setting – but to develop community care so that long-stay psychiatric hospitalisation could be avoided for all but the most extreme cases. Reform was undoubtedly necessary, not only were conditions in many asylums appalling due to over-crowding and brutal staff, but all too often people continued to be detained long after they had recovered. Critics argue, however, that reform was motivated as much by financial reasons as by compassionate ones. Gorsky, for example, claims that deinstitutionalisation was "neither liberating nor humane" and that "it was economics, not effective pharmacotherapies which explain [it]."²⁴ Due to the costs involved in implanting the proposed reforms, and the lack of funding as a result of the on-going economic crisis, the report did not give a precise date for the reform to be completed and community care did not become fully part of official government-funded policy until the mid-1980s.

- 17 During this same period, the *Isle of Wight Studies*, carried out by Michael Rutter, provided evidence of the need for specific policies for children and adolescents. Not only did Rutter's studies give precise figures on the rate of mental disorders in children, and proof of the role of family dysfunction in the development of psychopathologies, but they also showed that rates of mental disorders varied according to the areas in which the children lived, suggesting that socio-economic conditions had an effect on children's mental well-being. The publication of these studies led to similar studies of other populations, such as the 1983 Richman *et al.* *Waltham Forest Study*, which reinforced Rutter's findings and brought to light other elements, including the fact that behavioural problems in pre-schoolers were often a precursor of later disorders. Other studies began to take an interest in psychopathology from a developmental perspective and sought to classify which deviations from the norm should be considered pathological.²⁵ All these studies emphasised the necessity of systematic, standardized methods and measurement, and highlighted the need to treat children as soon as problems started to emerge.
- 18 Setting up effective community care for children and adolescents proved to be more complicated for children than for adults due to the existence of the 1973 *National Health Service Reorganisation Act* which created Area Health Authorities (AHA) responsible for the planning and delivery of healthcare services. The majority of the staff in the child guidance clinics fell under the responsibility of the new AHAs, but social workers, who played a vital role in the way the clinics were run, found themselves under the authority of local authority social services departments. Child and adolescent mental health community care thus suffered from the difficulty of co-ordinating two different services, and the problem of securing funding from two different sources. Williams and Kerfoot suggest that resources for mental health care were inadvertently reduced still further as a result of the 1980 *Education Act*, which introduced the process of "statementing" for special needs. This resulted in educational psychologists spending most of their time working with schools to assess pupils' needs rather than in child guidance clinics providing therapy to children with poor mental health.²⁶

- 19 Things came to a head in 1986 with a report by the Health Advisory Services entitled *Bridge Over Troubled Waters* which highlighted the problems within child and adolescent mental health care, in particular the lack of adolescent in-patient beds. In 1987, as a direct result of this report, a unified Child and Adolescent Mental Health Service (CAMHS) was finally created within the NHS. In their history of the first eighteen years of CAMHS, the psychiatrists David Cottrell and Abdullah Kraam, claim that it is not altogether clear what finally pushed the government into creating a specific policy. They suggest that it was probably a combination of a change in three factors in the way society viewed teenagers: firstly an alarmist media focus on “*declining family values*”, teenage pregnancies and single-parenthood, secondly an increase in reports of sexual abuse of children and the consequent belief that children needed to be protected more effectively, thirdly a growing international recognition of the rights of children which culminated in the publication of the *United Nations Convention on the Rights of the Child* in 1989.²⁷
- 20 Although all authorities were required to set up specific child and adolescent mental health services, there was initially no national policy on how the service should be run, no definition of who was eligible for the service and no advice as to what treatments should be offered. Precise guidelines were finally established almost a decade later largely thanks to Virginia Bottomley, the Secretary of State for Health from 1992 to 1995, who had worked as a social worker in a child guidance clinic before becoming an M.P. Bottomley commissioned a national review of CAMHS which was published in 1995 under the title *Together We Stand*. This detailed report drew attention to the absence of overall strategy, the widely varying expenditure for the same treatment from one area to another, and the fact that access to services depended more on geography than on need. Its main recommendation was that CAMHS should be reorganised into four tiers, each of which would offer a different level of help depending on the severity of the problem.
- 21 The four-tier system was rapidly implemented nationwide and continues to form the basis of CAMHS care today. Tier 1 is a universal service which covers all children. Its aim is to promote good mental health and it is carried out by people who are not mental health specialists such as G.P.s, health visitors, school nurses, teachers, social workers and youth justice workers. Tier 2 is a targeted, early intervention service for those at risk of developing mental health problems and is delivered by a trained mental health specialist such as a counsellor or a psychologist. Tier 2 services can operate either within a specialised CAMHS clinic or an out-reach basis, for example in a G.P. surgery or in a school. Tier 3 is aimed at those with more severe, complex or persistent disorders, and the services are delivered by a multi-disciplinary team working either in a community clinic or a hospital out-patient unit. Team members include child and adolescent psychologists, psychotherapists, psychiatric nurses, psychiatrists as well as occupational therapists, family therapists and social workers. Tier 4 are highly specialised services for the most complex cases. They are usually hospital-based and include both day units and in-patient units.
- 22 Initially the tiers system was greeted with optimism. The child guidance clinics and hospital services had finally been combined, the tiers seemed to offer clear guidelines for organising treatment, and there was money available to implement the changes. In 1999, the Labour government announced that over the next three years they would make an additional £84m available from the NHS Modernisation Fund for core CAMHS services. A further £20m was promised in 2004/5 and another £50m in 2005/6. Local authorities also gave money to help set up and run these new services. However, although new money did

undoubtedly enter the service, doubts were expressed about how much money actually arrived at its intended destination²⁸ and there were criticisms that the extra money was used to pay for new managers rather than to recruit more clinicians.²⁹

- 23 The internal organisation of both Tier 2/3 CAMHS clinics and Tier 4 in-patient units reflected the philosophy of the child guidance clinics with the young person being treated by a team, usually a psychiatrist, a psychologist or psychotherapist, very often a social worker and sometimes a family therapist. However, the same problems that existed in the child guidance clinics also persisted, most notably a lack of provision in many areas for 16-18 year olds who were considered too old for CAMHS but too young for adult services.

30

- 24 Almost from the start, a number of other problems were also apparent. Few studies existed which measured outcomes of different treatments for children and adolescents and even the first NICE guidelines did not contain specific guidelines for young people – in 2005 Cottrell and Kraam could only say that “*CAMHS-specific guidelines on depression, attention deficit disorder and obsessive compulsive disorders are in the pipeline.*”³¹ The increase in the number of referrals was not matched by an increase in the number of staff so that in some areas it was becoming difficult to provide long-term psychotherapy. Clinicians were increasingly expected to “*be accountable to external bodies rather than the patient*”³² which resulted in pressure on Tier 3 services to provide drugs rather than therapy, despite the fact that there were no long-term studies on the side-effects of psychiatric medication on under-eighteens. Thus although the same tiers existed throughout the country, they did not provide the same types of treatment, and there was no unified approach as to how the tiers were administered. A briefing report by the Children’s Commissioner as late as 2017 stated that:

There were no children’s mental health national targets until last year [...] for children with emerging problems. There is no clear expectation placed on local areas about which services should be provided, or how ill a child needs to be before they should receive care. [...] The evidence that has been collected, by myself and a range of other bodies, reveals a postcode lottery of care.³³

- 25 There was also concern that the tiers were too rigidly defined meaning children with complex problems, who did not fit neatly into one of the tiers, could end up receiving no treatment.

CAMHS in crisis: child and adolescent mental health care for the 21st century

- 26 The percentage of young people suffering from mental health problems has risen regularly since CAMHS was set up, although it is hard to find precise national statistics. The number of children seen by mental health services have only been collected regularly and collated since 2016 and although there were three surveys of adult mental health between 2000 and 2014, there was no full survey of child mental health between 2004 and 2018. The 2004 survey concluded that 7.7% of 5-10 year olds and 11.5% of 11-16 year olds suffered from a diagnosable mental health condition. It is the average of these two figures that gives the 10% (or 1 in 10 children) which is still regularly quoted by the media. Statistics from 2016 onwards show a regular increase both in the number of referrals and

in the number of young people under the age of 19 in contact with mental health services;³⁴ the latter figure rose from 96,789 in July 2016 to 218,871 in July 2018.³⁵ Various reasons have been put forward to explain this increase, including more pressure at school due to constant testing, the rise in poverty as a result of the politics of austerity, or quite simply more awareness of the symptoms of mental ill-health and a greater willingness to seek treatment. Whatever the reasons, better informed parents, and an increasingly consumer-society, have led to growing demands for child mental health care while at the same time, many Clinical Commissioning Groups have regularly decreased the proportion of their budgets that they allocate to CAMHS.³⁶

- 27 By the beginning of the 21st century it was becoming increasingly apparent that CAMHS was in crisis. In 2008 an independent CAMHS review concluded that the existing system had a number of serious problems, in particular long waiting times to access the services, significant differences in the availability of services depending on where the child lived and a lack of emergency services.³⁷ The review was particularly critical of the lack of in-patient beds, leading to patients being sent far away from their homes and families in direct contradiction of recommended practice which states the crucial role of “home-leave.” One of the obvious reasons for this was a lack of central planning, which had resulted in more beds in the South East than anywhere else in the country. As clinicians and user groups pointed out, it was not, however, simply a case of transferring some of the units in the South East elsewhere in the country as the total number of beds was insufficient.³⁸
- 28 Hopes of a reform were dashed by the election of the coalition government in May 2010 which introduced a policy of austerity in public services. According to Callaghan *et.al.*:

May 2010 represents the beginning of a clear shift in the direction of mental health policy. Rather than ‘evolving’ from previous policy, the decision was to effectively start over, rendering pre-2010 policy generally obsolete. Concepts such as ‘Universal CAMHS’ fell out of use, and the emphasis shifted from policy specific to CAMHS, to a more generic set of policies aimed at ‘all people.’³⁹

- 29 In their analysis of the language used in government policies before and after 2010, Callaghan *et.al.* show that there has been a gradual shift towards a biological interpretation of mental health, which excludes socio-economic causes and the effects of the politics of austerity on whole groups of society. Significantly, children and adolescents are no longer seen as a group apart with specific needs and the terms “child” and “adolescent” no longer feature in government reports. This is apparent even in the titles of the reports; in 2003 the report was called *Every Child Matters*, in 2011, *No Health Without Mental Health*.
- 30 In response to a parliamentary question in 2015, NHS England reported that £50 million had been cut from CAMHS budgets between 2010 and 2013. The Children’s Commissioner estimated that this meant that only 7% of NHS mental health funding went on children’s services.⁴⁰ This led to a media outcry and, as a result of the 2015 *Future in Mind* report, the government promised to invest an extra £1.4 million over five years in order to implement the report’s recommendations. However, CAMHS funding is not ring-marked within overall NHS budgets and a Young Minds’ enquiry into how the money was being spent discovered that “nearly two-thirds (64%) of CCGs [who replied] used some or all of the extra money to backfill cuts or to spend on other priorities.”⁴¹

- 31 The current government places great emphasis on early intervention and on actions which increase resilience. Early intervention is justified financially by the figures given in the 2017 briefing report which noted that the majority of the CAMHS budget went towards helping those with severe needs: 38% went towards in-patient costs, which is accessed by only 0.001% of children aged 5-17, and 46% went on providing CAMHS community services which are accessed by just 2.6% of children. The report underlined the high cost of in-patient treatment (on average £61,000) compared to just £5.08 per pupil for an emotional resilience programme in a primary school. It went on to argue that *“a targeted therapeutic intervention delivered in a school costs about £229 but derives an average lifetime benefit of £7,252. This is a cost-benefit ratio of 32-1.”*⁴² This emphasis on value for money is a clear departure from the original CAMHS policies which focussed on every child’s right to a happy childhood.
- 32 Although the briefing stated clearly that “any child with a more serious condition [should be] able to access high-quality, specialist support within clear waiting-time standards,”⁴³ early intervention is being promoted without any increase in funding, which means it can only be undertaken by diverting existing funds. CAMHS clinicians have warned that this means the most complex cases are likely to receive less treatment. My cynical view is that the government wants to stop treating complex cases for two reasons. First the government wants to use statistics to prove that its policy of early intervention works and to do this it needs to focus on children with simple problems who can be treated quickly. Second those children and adolescents with complex cases are likely to have recurrent mental health problems throughout their lifetime. There is, therefore, no point in spending money on them when they are young to improve their experience of childhood as they will continue to be a burden on society throughout their lives.
- 33 The government’s frequent use of the term resilience suggests that young people are to a certain extent responsible for their own mental health – those who develop resilience get better, while those who do not become one of those mentally ill adults who *“represent up to 23% of the total burden of ill health in the UK.”*⁴⁴ By ignoring the role of socio-economic conditions on children’s mental health, current government statements about young people’s mental health reproduce *“dominant discourses of strivers and skivers that characterise public debate on benefits and welfare and that function to problematize and demonise poverty and dependency.”*⁴⁵
- 34 Recent changes in society’s attitudes towards childhood may have helped to make the current government’s policies towards CAMHS more palatable for some voters. Gianna Knowles suggests that society currently recognises two categories of children, and although attitudes towards both categories can cause psychopathologies, only one type of child is seen as deserving of help. According to Knowles, the first category is a variant on the eighteenth-century romanticised view of childhood being a pure state. Adults feel the need to protect children’s innocence and do so by keeping them in an infantilized state. This creates a tension with the child’s natural desire to explore the world and can lead to anxiety disorders. These anxious children are generally seen as deserving of help to develop the resilience necessary to succeed in life. The other category of children stems from the nineteenth-century idea of the delinquent child who needs to be controlled. This vision of what Knowles terms the “demon” child has been promoted by the media since the 1990s, leading parents and schools to demand treatment for what should be regarded as normal childhood behaviour, and causing a rise in diagnoses of ADHD and conduct disorders.⁴⁶

- 35 It is not only the media vision of childhood which has changed over recent years. Recent biological research supports the idea that the development of the adolescent brain is only complete when the person is in their mid-twenties.⁴⁷ Most long-term psychopathologies first become apparent in the second half of the teenage years – according to the government’s 2011 mental health strategy for England, *No Health without Mental Health*, half of those with life-time mental health problems first experience symptoms by the age of 14.7 years and three quarters before their mid-twenties. There is therefore both a biological and an administrative argument for extending CAMHS up to the age of twenty-five. Some mental health professionals have suggested that CAMHS should be split into two services: one for children and younger teenagers dealing primarily with behavioural and emotional disorders and one for older teenagers and young people in their early twenties dealing with the psychopathologies and personality disorders that are likely to continue into adulthood. A few CAMHS, such as Brighton and Hove, or Tavistock and Portman, have already implemented this idea and have created a “Young Adult Service” for those aged fourteen to twenty-five.
- 36 There are also attempts by some CAMHS to rethink the tier system. Hertfordshire, for example, is one of ten trusts which plan to replace the existing system by 2020 with a new system called “*I Thrive*,” a framework developed by the Anna Freud Centre and the Tavistock and Portman NHS Foundation Trust. The new system still divides young people’s needs into different categories, which to some extent overlap with the existing tiers, (“*Thriving*”, “*Coping*”, “*Getting Help*”, “*Getting More Help*”, “*Risk Support*”), but the new system has been designed as a continuum, with the idea that children and young people can move easily from one category to another, and the different categories are represented visually as a circle rather than as the levels of a pyramid. Whether these changes will be anything other than cosmetic remains to be seen – the Hertfordshire report notes that the effectiveness of these proposed changes is dependent both on continued funding, and on the ability to recruit and retain enough qualified staff.⁴⁸

Conclusion

- 37 There has undoubtedly been considerable progress in the services available for mentally unwell children and teenagers over the past seventy-years. However, despite the growing media interest in mental health,⁴⁹ and the 2018 government report *Closing the Gap* which specifically states that: “*mental health must have equal priority with physical health, that discrimination associated with mental health problems must end and [...] everyone who needs mental health care should get the right support, at the right time*,”⁵⁰ nationwide availability of high-quality, effective care for those children and adolescents suffering from severe and complex mental health problems looks far from certain. Although child psychiatry is now a fully-established medical speciality, and there are specific training programmes for child and adolescent psychotherapists, there is no ring-fenced budget for CAMHS, and working conditions for CAMHS clinicians are becoming increasingly difficult due to insufficient resources. The driving force behind current government policies is not child welfare but financial savings. Laudable as their aim is to bring mental health services within all schools, there still needs to be properly funded accessible care available nationally to all those who need it.
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NOTES

1. William Parry-Jones, "The Future of Adolescent Psychiatry", *British Journal of Psychiatry* 1995, 166, p. 299.
2. Martin Gorsky, "The British National Health Service 1948-2008: A Review of the Historiography", *Social History of Medicine*, 21:3, 2008, p. 442. The other "subaltern narratives" are "public health" and "care for the elderly".
3. For reasons of space I have excluded the care of children suffering from developmental delays and learning disabilities. The creation of specific services for these children followed a slightly different path.

4. Alexander von Gontard, "The Development of Child Psychiatry in 19th Century Britain", *Journal of Child Psychology and Psychiatry*, 29:5, 1988, p. 579. Initially the term "moral insanity" included traits that are today considered to be symptomatic of Autistic Spectrum Disorder: "social withdrawal, difficulty making and maintaining friendships, intense interest in precise topics such as railways timetables". The same term was later used to refer to what would currently be called psychopathy, sociopathy and conduct disorders
5. *Ibid.*, p. 580
6. William Parry-Jones, "Historical Themes", in Jonathan Green and Brian Jacobs (eds.), *In-patient Child Psychiatry: Modern Practice, Research and the Future* (London, Routledge, 2002), p. 26.
7. D.T. Maclay, "The Working of a Child Guidance Clinic". *Health Education Journal*, 26:4, 1967, p. 171.
8. John Stewart, "'The dangerous age of childhood': child guidance in Britain c.1918-1955", *History and Policy*, Oct. 2012, <http://www.historyandpolicy.org/policy-papers/papers/the-dangerous-age-of-childhood-child-guidance-in-britain-c.1918-1955> consulted 1 June 2018.
9. *Ibid.*
10. Maclay, p. 174.
11. Evans Bonnie *et.al.* "Managing the 'unmanageable': interwar child psychiatry at the Maudsley Hospital, London", *History of Psychiatry*, 19:4. 2008, p. 458 and p. 461.
12. The NAMH was renamed "Mind" in 1972 and is today one of the leading mental-health charities.
13. "A History of Mind", <https://www.mind.org.uk/about-us/what-we-do/our-mission/a-history-of-mind/> consulted 30 March 2018.
14. Hersov, Lionel, "Child Psychiatry in Britain: the last 30 years", *Journal of Child Psychology and Psychiatry*, 27: 6, 1986, p. 783.
15. In 1944 there were 95 clinics. Christopher J. Wardle, "Twentieth-Century Influences on the Development in Britain of Services for Child and Adolescent Psychiatry", *British Journal of Psychiatry*, 159, 1991, p. 56.
16. Framrose, Rustam, "The First Seventy Admissions to an Adolescent Unit in Edinburgh: General Characteristics and Treatment Outcome", *British Journal of Psychiatry*, 126, 1975, p. 380.
17. Parry-Jones, William, "The History of Child and Adolescent Psychiatry: Its Present Day Relevance", *The Journal of Child Psychology and Psychiatry*, 30:1, 1989, p. 7.
18. *Ibid.*, p. 8.
19. Wardle, *op. cit.*, p. 60.
20. For further details see Hersov, p. 785.
21. Rey, Joseph *et.al.*, "History of Child Psychiatry" in *IACAPAP Textbook of Child and Adolescent Mental Health*, 2015, <http://iacapap.org/wp-content/uploads/J.10-History-Child-Psychiatry-2015.pdf> consulted. 25 May 2018. p. 16.
22. Hersov, p. 784.
23. *Better Services for the Mentally Ill*, Cmnd 6253, HMSO London, 1975, par. 11.5.
24. Gorsky, p. 442.
25. For full details of all these studies see Michael Rutter, "Child and Adolescent Psychiatry: Past scientific achievements and challenges for the future", *European Child and Adolescent Psychiatry*, 19:9, 2010, pp. 689-703.
26. Richard Willams and Michael Kerfoot, *Child and Adolescent Mental Health Services: Strategy, Planning, Delivery and Evaluation*, Oxford University Press, 2005, p. 17.
27. David Cottrell and Abdullah Kraam, "Growing Up? A History of CAMHS (1987-2005)", *Child and Adolescent Mental Health*, 10: 3, 2005, p. 111.
28. William & Kerfoot, p. 25
29. John Turner *et. al.* "The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research", *Medical History*, 59(4), 2015, pp. 599-624

30. Although the Tiers system was implemented across the country, the upper-age limit has always been decided on a local level.
31. Cottrell & Kraam, p. 114.
32. See John Turner *et. al.* "The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research", *Medical History*, 59(4), 2015, pp. 599–624.
33. Children's Commissioner, *Briefing: Children's Mental Health Care in England*, October 2017, <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/10/Childrens-Commissioner-for-England-Mental-Health-Briefing-1.1.pdf> consulted April 15 2018, p. 2
34. "In contact" literally means that they are "in contact." They may just be on a waiting list and not actually receiving any treatment.
35. See NHS Digital. <https://digital.nhs.uk/> consulted 20 July 2018.
36. See British Medical Association, *Lost in Transit: funding for mental health services in England*, 2018.
37. Jo Davidson. *Children and young people in mind: the final report of the National CAMHS Review*, 2008, <http://webarchive.nationalarchives.gov.uk/20090615071556/http://publications.dcsf.gov.uk/eOrderingDownload/CAMHS-Review.pdf> consulted 15 April 2018.
38. Simon Gowers & Andrew Cotgrove, "The Future of In-patient Child and Adolescent Mental Health Services", *British Journal of Psychiatry*, 183:6, 2003, p. 479.
39. Callaghan, Jane, Lisa Chiara Fellin, Fiona Warner-Gale, "A Critical Analysis of Child and Adolescent Mental Health Services policy in England", *Clinical Child Psychology and Psychiatry*, 22:1, 2017, p. 111.
40. Children's Commissioner, *Briefing*, p. 16
41. Young Minds, "Children's mental health funding not going where it should be," December 2017, <https://youngminds.org.uk/media/1285/foi-2016-press-release.pdf> consulted 29 March 2018.
42. Children's Commissioner, *Briefing*, p. 4.
43. *Ibid*, p. 6
44. H.M. Government, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of all Ages* 2011, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf consulted 29 March 2018, p. 10
45. Callaghan *et.al.*, p. 119
46. Gianna Knowles, *Ensuring Every Child Matters: A Critical Approach*, London: South Bank University, 2009. p. 3 and p. 6.
47. See for example William Parry-Jones, 1995, p. 300.
48. Healthy Young Minds in Herts, Child and Adolescent Mental Health Services (CAMHS) Transformation Plan for Hertfordshire 2015-2020, Herts. County Council, 2017, http://www.enhertscg.nhs.uk/sites/default/files/Healthy%20Young%20Minds%20in%20Herts%20plan%202015-20_Oct%202017%20refresh_final.pdf consulted 29 March 2018.
49. See for example: N.A. Murphey *et. al.*, "The changing face of newspaper representations of the mentally ill", *Journal of Mental Health*, 2013, 22(3), pp.271-82 which notes that "the rate of increase [in the number of articles on mental health in British newspapers] was far greater than that for the increase in the total number of articles carried in the press over this time period [2003-2013]" (271).
50. Department of Health, *Closing the Gap: Priorities for essential change in Mental Health*, 2014, p. 4.

ABSTRACTS

The creation of a specific child and adolescent mental health service within the NHS was influenced by a number of factors including changes in adult mental health policies, the evolution of society's attitudes towards children and parenting, and a greater biological and psychological understanding of how children develop. In the early years of the NHS, care for young people with mental health problems was split between child guidance clinics and hospitals with little communication between the two. A single unified service was not created until 1987, and national guidelines for how the service should be organised were drawn up only in 1995. The effectiveness of Child and Adolescent Mental Health Services (CAMHS) has, however, been hampered both by a failure to implement the guidelines in the same way throughout the country, and by a lack of financial investment.

La création d'un service de santé mentale spécifique pour enfants et adolescents au sein du NHS a été influencée par plusieurs facteurs, notamment la modification des politiques de santé mentale des adultes, l'évolution des attitudes de la société à l'égard des enfants et de la parentalité, ainsi qu'une meilleure compréhension du développement biologique et psychologique des enfants. Aux premières heures du NHS, l'offre de soins dispensés aux jeunes souffrant de problèmes de santé mentale était assurée soit par des cliniques d'aide à l'enfance soit par des hôpitaux, avec toutefois peu de communication entre les deux institutions. Un service unique et unifié n'a été créé qu'en 1987 et des directives nationales sur son organisation n'ont été élaborées qu'en 1995. L'efficacité de CAMHS a toutefois été entravée par une incapacité à mettre en œuvre les directives de de façon homogène et uniforme à travers le pays et par un manque d'investissements financiers.

INDEX

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