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Referrals to child psychiatry—a survey of staff attitudes

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Abstract

A questionnaire study was conducted in a health district to evaluate the attitudes of paediatricians and child psychiatry staff as to which categories of problems should be referred to child psychiatry. In the majority of categories the two groups disagreed as to the frequency with which the problem should be referred. In the categories relating to child sexual abuse responses were often not in accord with Department of Health and Social Security guidelines. Reasons for not referring were also looked at and again it was found that there were a number of significant differences in opinion as to what are reasons for not referring to child psychiatry. Both groups agree that lack of communication is a reason for non-referral. Some suggestions are made as to how this problem could be addressed.

The association between child psychiatry and paediatrics has been widely commented on during the past 30 years.[1–5] We wished to explore whether locally there was agreement between disciplines as to the appropriateness of referral of various clinical problems and to look at factors that might lead to not referring.

Method

The study was a survey, using specially designed questionnaires, of paediatricians (all grades) and child psychiatry staff (psychiatrists, clinical psychologists, child psychotherapists, and social workers) in an inner London health district. The decision to survey only medical staff in paediatrics but all professional child psychiatry staff reflects the fact that whereas referral, although influenced or initiated by other professions, is primarily a medical decision, the child psychiatry departments assess and treat on multidisciplinary lines.

THE QUESTIONNAIRES

Two questionnaires were used, one for paediatricians and one for child psychiatry staff. They varied slightly in format, but were identical in content. Both questionnaires consisted of two parts.

Part 1

The aim of part 1 was to determine whether paediatricians and child psychiatrists agree as to which type of clinical problem should be referred to child psychiatry. Part 1 of the paediatricians' questionnaire asked paediatricians how often they would refer to child psychiatry a range of clinical problems seen as inpatients and outpatients. Part 1 of the child psychiatry questionnaires asked child psychiatry staff how often they think paediatricians should refer these problems to the child psychiatry department.

The clinical problems were selected for inclusion after a review of the literature[6–8] and after discussions with our colleagues. Our list was not exhaustive but represented most of the common reasons for referral to child psychiatry.

Respondents were asked to indicate how frequently they felt a category of problem should be referred by answering 1–4 where 1=rarely or never, 2=sometimes, 3=frequently, and 4=always or nearly always. The categories of problems are shown in table 1.

Part 2

This section looked at factors that might negatively influence referral. The list of possible reasons we used was compiled after a review of the literature and after discussions with our colleagues. These possible reasons were given in the form of a list of statements and the respondents were asked to indicate 'yes' or 'no' to each of these depending on whether or not they thought the reason relevant in the decision not to refer to child psychiatry. These statements are shown in table 2.

In this part of the questionnaire we were asking paediatricians direct attitudinal questions, but the child psychiatry staff were being asked to speculate whether they felt certain factors affected the paediatricians' decision to refer. Both parts of the questionnaires included a section inviting further comments from the respondents. Questionnaires were sent to all the staff indicated above with an explanatory letter and prepaid reply envelopes. A reminder and a second copy of the questionnaire were sent if there was no response within three weeks. We indicated that respondents could reply anonymously if preferred.

Results

RESPONSE RATES

The response rate to the questionnaires was 23/37 (67·6%) for paediatricians and 25/37 (67·6%) for child psychiatry staff.

We originally recorded the results by subgrouping the respondents according to department (paediatrics or child psychiatry), hospital or centre and either status, if paediatric, or discipline, if child psychiatric (for example, senior

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Table 1 Results to part 1 of the questionnaire: which type of clinical problem should be referred to child psychiatry

Category of problem	*Department**	*Respondents (%) who refer:*				*Total No of responses*	*Significance*
		Always	*Frequently*	*Sometimes*	*Never*		
(A) Self poisoning	P	71	24	0	5	21	NS
	CP	88	8	4	0	25	
(B) Emotional/ behavioural problems	P	4·5	32	54·5	9	22	p<0·01
	CP	56	28	11	7	25	
(C) Obesity	P	0	0	55	45	22	p<0·01
	CP	12	24	60	4	25	
(D) Helping families/children cope with terminal illness	P	22	13	38	17	22	NS
	CP	8	48	40	4	25	
(E) Helping famillies/children cope with physical handicap/chronic illness	P	0	17	61	22	23	NS
	CP	0	16	80	4	25	
(F) Repeated admissions (because mother cannot cope)	P	0	22	48	30	23	NS
	CP	20	8	64	8	25	
(G) Physical illness exacerbated by psychological problems	P	4	26	52	17	23	p<0·01
	CP	20	48	8	0	25	
(H) Diagnostic difficulties	P	16	36	40	8	25	p<0·01
	CP	53	22	20	5	22	
(I) Child sexual abuse+behavioural/ emotional problems	P	53	19	19	9	21	p<0·01
	CP	88	8	4	0	25	
(J) Help with diagnosing child sexual abuse	P	27	27	14	32	22	p<0·01
	CP	44	36	16	4	25	
(K) Encopresis	P	17	39	31	13	23	NS
	CP	16	64	20	0	25	
(L) Enuresis	P	0	0	47	53	23	p<0·01
	CP	12	60	28	0	25	
(M) Admission problems/ separation anxiety	P	0	19	48	33	21	p<0·01
	CP	20	40	28	12	25	
(N) Parental neglect/ non-accidental injury	P	4	13	48	35	23	p<0·01
	CP	32	28	40	0	25	
(O) Drug/alcohol problems in child	P	32	55	13	0	22	NS
	CP	44	40	16	0	25	
(P) Anxiety over medical/ nursing procedures	P	0	5	43	52	21	p<0·01
	CP	8	20	52	20	25	
(Q) Behaviour disturbance on ward	P	14	24	52	10	21	p<0·01
	CP	50	33	17	0	25	
(R) Mother has difficulties with baby feeding/sleeping	P	4	13	48	35	23	p<0·01
	CP	36	28	36	0	25	
(S) Don't know what else to do	P	4	4	57	8	23	p<0·01
	CP	24	16	44	16	25	

*P=paediatrics, CP=child psychiatry.

Table 2 Results to part 2 of the questionnaire: factors that might negatively influence referral

(1) Referral not acceptable	P	100	0	22	NS
	CP	100	0	25	
(2) Stigmatises child or family	P	14	86	22	P<0·01
	CP	75	25	24	
(3) Delay before first appointment too long	P	45·5	55·5	22	P<0·01
	CP	52	48	25	
(4) Delay before treatment too long	P	41	59	22	NS
	CP	50	50	24	
(5) Treatment range narrow/inappropriate	P	50	50	22	P<0·01
	CP	68	32	25	
(6) Psychiatric process damages child	P	5	95	21	P<0·01
	CP	41	59	22	
(7) Lack of child psychiatry inpatient/ day patient facility	P	48	52	21	NS
	CP	65	35	23	
(8) Inadequate communication between departments	P	77	23	22	NS
	CP	24	16	25	
(9) Case is 'lost' to child psychiatry after referral	P	40	60	22	NS
	CP	62·5	37·5	24	
(10) Medical opinion sought†	P	41	59	22	NS
	CP	52	48	25	
(11) Opinion of consultant psychiatrist sought but difficult to obtain	P	27	73	22	NS
	CP	56	44	25	
(12) If all cases referred child psychiatry system would be flooded	P	32	68	22	NS
	CP	36	64	25	
(13) Referral does not achieve much	P	48	52	21	NS
	CP	72	28	25	

*P=paediatrics, CP=child psychiatry.
†A medical opinion sought but child frequently seen by non-medical child psychiatry staff.

house officer or psychologist). However, there were no superficial differences between these subgroups within each department and the numbers in some of the subgroups were very small and therefore the responses were pooled according to department for analysis.

Part 1

Results are given in table 1. The percentage of paediatricians and child psychiatry staff responding with either 1, 2, 3, or 4 to each category of problem A to S is given. The total number of responses to each category is also given. These totals vary as a number of questionnaires were only partially completed. The results were analysed using non-parametric correlation coefficient Kendall's τ for tied ranks to see if there was a significant difference between the responses of the paediatricians and the child psychiatric staff.[9] The rationale for using this method is discussed by Priest.[10] The result of this analysis is given in table 1.

There was a significant difference in the responses to 13 out of 19 categories. Particularly striking disagreement was seen in the categories of obesity, enuresis, and 'behavioural problems referred directly to the paediatrician'. When

there was a difference in responses it was always that the child psychiatry staff indicated that the case should be referred and the paediatricians indicated that it should not.

There was agreement between the two groups' responses to four of the categories. Firstly, both paediatricians and child psychiatry staff agreed that category A (self poisoning) and O (drug and alcohol problems) should be referred to child psychiatry. Both groups also agreed that categories E (helping families and children cope with physical handicap or chronic illness) and F (children with repeated admissions because the mother cannot cope) should not be referred to child psychiatry.

Part 2

We recorded the percentage of 'yes' and 'no' responses given by both groups of staff to each of the statements 1 to 13. The results are given in table 2. Again, some of the questionnaires were incomplete and so the total number of responses varied. These results were analysed using the χ^2 test with Yates's correction for continuity. Significant differences were found in the responses to two of the statements. To statement 2 (referral stigmatises the child or family) paediatricians indicated that this was not a reason for not referring whereas child psychiatry staff thought this was a reason for not referring. Paediatricians responded to statement 6 (the psychiatric process damages the child) by indicating that this was not a reason for not referring whereas child psychiatry staff were divided in their responses to this statement.

Both groups agreed that statements 1 (referral not acceptable to the family) and 8 (inadequate communication between the departments after the child is seen) are reasons for not referring. Both groups also agree that statement 12 (if all appropriate cases were referred the child psychiatry department would be flooded) was not a reason for not referring.

COMMENTS

Some of the comments made in response to the question posed at the end of part 2 of the questionnaires: 'Do you think there are any other reasons for not referring to the child psychiatric department' are given below. The asterisked comments were made by anonymous respondents.

Comments from paediatricians

- 'Psychiatrists seem aloof from everyday problems that families face and from problems on the ward'.
- 'The approach of the psychiatric staff is *not* appropriate for the majority of our patients. The families most often needing help are emotionally damaged mothers in very deprived settings who need a behavioural approach weighted with problem solving—Jungian therapy is not accepted. . . Middle and upper middle class with support and intelligence can make use of the service'.
- 'There is a cultural gap between the local population and the staff of the child psychiatry clinics—more medical approach and perhaps more work with other professionls in the community might be more helpful'.
- 'Reluctance on the part of the child psychiatrist to see the patient'.
- 'Child psychiatry should be part of the range of services provided by paediatrics and not a separate department to whom referrals are made'.
- 'A child psychiatrist is not present on site as part of the paediatric team'.
- 'I feel that both paediatricians and child psychiatric trainees should spend six months in each other's professions in order to better understand the job'.
- 'Heavy demand on parents with frequent (two to three times a week) therapy sessions'.*
- 'General requirement that both parents should be prepared to go to the initial appointment'.*
- 'Low profile of psychiatric department within paediatric department—but improving'.

Comments from child psychiatry staff

- 'Paediatricians sometimes think they can offer the same help as child psychiatry would give'.
- 'Resistance to conceptual basis of child psychiatry/psychotherapy'.
- 'Some paediatricians (not all) may find it hard to accept that they are not experts in all aspects of illness in children. . . . in the good old days paediatricians did have to cope with all aspects of childhood illness, including psychological aspects. Lack of child psychiatric resources in some areas may mean that paediatricians are still dealing with what should ideally be dealt with by child psychiatrists'.
- 'Paediatricians' own anxieties about (a) emotions being stirred up, (b) working with other professionals, (c) losing control of the situation'.
- 'The department is seen as too narrow in its range of work and intransigent'.
- 'Ignorance and lack of communication between the two departments'.

There were no comments made in response to part 1 of the questionnaire.

Discussion

The response rate was 67·6% for both paediatricians and child psychiatry staff. Some of the junior paediatric staff gave the reason that they felt too inexperienced to participate. There were only two anonymous respondents and these were both paediatricians.

One problem we came across that affected all parts of the study concerned was what was meant by referral. Some staff though that a discussion of the case with a member of the child psychiatric department constituted a referral whereas others defined referral as asking a

member of the child psychiatry department to see the child and/or family.

Part 1 of the questionnaire

There was agreement between paediatricians and child psychiatric staff on only a few categories of problems and significant disagreement was seen in the responses of the two groups to most of the categories. In cases of child sexual abuse with emotional or behavioural disturbance 72% of paediatricians and 96% of child psychiatry staff said they would always or frequently refer. This difference is significant and contradicts Department of Health and Social Security (DHSS) guidelines that recommend referral to child psychiatry.[11] Interestingly, 80% of child psychiatry staff and 54% of paediatricians favoured always or frequently referring cases requiring help with the diagnosis of child sexual abuse. This difference is significant and again contradicts DHSS guidelines, which advise that such cases should not be referred to child psychiatry.[11]

It was noted that when there was a significant difference between child psychiatry staff and paediatricians it was always that the child psychiatrists were in favour of referral and paediatricians were against it. One possible explanation of these findings is that paediatricians and child psychiatrists may have different ideas about these problems. It is likely that paediatricians would see a broad range in severity of these cases but the child psychiatric staff may only see the more severe cases. Another possible cause of these differences may be the apparent lack of communication between the two departments. This idea is supported by the results of part 2 of the questionnaire and by some of the comments made by the respondents.

Part 2 of the questionnaire

This part looked at reasons for not referring to child psychiatry. Unfortunately, it is not clear whether responding 'no' in this part of the questionnaire indicates that the respondent thinks that the statement is incorrect or that the statement is correct but not relevant in influencing non-referral. The questionnaire has compounded these two distinct questions and a further study is needed to overcome this problem. Some interesting results were seen in the responses to statement 5 ('range of treatment too narrow or inappropriate') and statement 13 ('referral to child psychiatry does not seem to achieve much'). A large number of child psychiatry staff responded 'yes' to both statements. This could mean that either this group is dissatisfied with their work or that they feel that they are poorly perceived by their paediatric colleagues. The comments received from the paediatricians supports the second conclusion.

Both departments agreed that inadequate communication was a reason for non-referral. The agreement on this issue is striking and is reflected in some of the respondents' comments. It is suggested that this may be underlying some of the differences found in part one of the study.

This could be readily addressed by more active attempts at communication between the two groups. Joint ward rounds or clinical meetings could be a suitable forum in which this could take place. If all the cases that the child psychiatry staff suggest were referred it would undoubtedly result in a flooding of the service. More consultative work and mutual education could take place in such meetings thereby reducing the perceived need for many of these referrals. Also, perhaps a jointly formulated referral policy could be initiated.

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1 Eisenberg L. The relationship between psychiatry and pediatrics: a disputatious view. *Pediatrics* 1967;**39**:645–7.
2 Anders TF. Child psychiatry and pediatrics—the state of the relationship. *Pediatrics* 1977;**60**:616–20.
3 Jellinek MS. The present status of child psychiatry in pediatrics. *N Engl J Med* 1982;**306**:1227–9.
4 Taylor DC. Child psychiatry/paediatric liaison: a discussion paper. *J R Soc Med* 1986;**79**:726–8.
5 Fritz CK, Bergman AS. Child psychiatrists characteristics as described by pediatricians in a national survey (1986–1987). *Int J Psychiatry Med* 1986;**16**:91–100.
6 Mrazek D. Child psychiatric consultation and liaison to paediatrics. In: Rutter M, Hersov L, eds. *Child and adolescent psychiatry—modern approaches*. 2nd Ed. Oxford: Blackwell Scientific, 1976.
7 Lewis M. Child psychiatric consultations in pediatrics. *Pediatrics* 1978;**62**:359–64.
8 Monnelly EP, Lanzito BM, Stewart MA. Psychiatric consultations in a children's hospital. *Am J Psychiatry* 1973;**130**: 789–90.
9 Kendall MG. *Rank correlation methods*. 3rd Ed. London: Griffin, 1962.
10 Priest RG. The homeless person and the psychiatric services: an Edinburgh survey. *Br J Psychiatry* 1976;**128**:128–36.
11 Department of Health and Social Security. *Diagnosis of sexual abuse: guidance for doctors*. London: HMSO, 1988.