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PRACTICE OBSERVED

Practice Research

General practitioner referrals to a clinical child psychologist

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Abstract

An analysis of the problems that are referred by general practitioners to a clinical child psychologist working in the community is presented. To illustrate some of the principles of assessment and management an example from each of three main categories—behaviour problems, emotional disturbances, and disorders of function—is given.

Introduction

Clinical child psychologists often work in the community and have consulting sessions in health centres or elsewhere. Most of the 300 clinical child psychologists in England and Wales, however, are based in hospitals,[1] and their availability varies from one health district to another. The role of both the clinical child psychologist and the adult clinical psychologist working in the community is developing.[2 3] General practitioners refer patients to them directly, and when sessions are held in health centres communication between the general practitioner and the clinical psychologist is greatly facilitated. Sometimes referrals may be made by other members of the primary care team, such as a health visitor, with the consent of the general practitioner. Clinical psychologists who work in the community also receive referrals from paediatricians and child psychiatrists in the same way as those who are based in hospital. Thus a child who is referred by a general practitioner to a paediatrician or a child psychiatrist may reach the clinical child psychologist indirectly. A separate psychological service is provided by educational psychologists for children who are referred mainly by teachers. Both educational and clinical psychologists may work in child guidance clinics alongside child psychiatrists, social workers, occupational therapists, and play therapists.

General practitioners may be uninformed of the types of problems that clinical child psychologists can help with. We therefore describe problems that have been referred directly by general practitioners to a community clinical child psychologist who was employed by a district health authority.

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Method

In 1981 a senior clinical child psychologist (EB) was appointed full time by Trafford District Health Authority to a community clinical psychology department that served children and adolescents who were under 18 years of age. Children were seen at the department, in their homes, and in health centres. Trafford is predominantly middle class: 66% live in owner occupied houses, and 7% of the population was born outside the United Kingdom.[4]

The records of all patients were reviewed, and those who had been referred directly from general practitioners were identified. The main problem in the referral letter from the general practitioner was summarised and classified. In each case the main problem that was treated was also recorded to allow comparison between the general practitioner's assessment at the time of referral and the psychologist's assessment.

Results

Sixty six patients (27% of referrals) under 18 were referred directly by general practitioners (table). Health visitors referred a further 9%, and the remainder of referrals was from paediatricians, clinical medical officers, psychiatrists, and cross referrals from educational psychologists.

The main problem stated in the general practitioner's referral letter and the problem treated by the psychologist were the same except for two (4%) patients. A girl who had been referred for anxiety and depression was later

diagnosed as suffering from early anorexia nervosa. A boy who had been referred for an emotional problem was treated for writing difficulties from which the anxiety was thought to stem. Three main categories covered all of the problems seen except that one child was sent for developmental assessment. An example from each category illustrates how the problems were managed.

Reasons for general practitioner referral to a clinical child psychologist (number of patients)

	Boys (n=45)	Girls (n=21)	Total (n=66)
Behaviour problems			
Aggression	8	1	9
Stealing	4	3	7
School refusal	2	1	3
Bullying	3		3
Tantrums	1	2	3
Wandering	1	1	2
Destructive behaviour	2		2
Sibling jealousy		1	1
Rebellion	2	1	3
Boy dressing in mother's clothes	1		1
Emotional disturbance			
Anxiety	3		3
Phobias	4	2	6
Psychosomatic	2	1	3
Bereavement reaction	1	1	2
Disorders of function			
Enuresis	6	2	8
Soiling	2		2
Sleep disorder	2	2	4
Eating disorder		3	3
Other			
Deviation from normal development	1		1

BEHAVIOUR PROBLEMS

Behaviour problems were the commonest and featured aggression and a wide variety of antisocial conduct.

Example—M, aged 8 years, was referred because of "disruptive and defiant" behaviour at home and at school, where he was being teased. The family comprised mother, father, M, and sister aged 7. M had always been "hard work"—poor sleeping habits, overactive, and destructive. The school reported that he appeared to be verbally quick and intelligent, but his reading, writing, and sports skills were poor and he was clumsy. The psychological problems caused by his short attention span, poor impulse control, and frustration with coordination problems were discussed with both parents. M was encouraged to practise giving himself verbal instructions to help control his impulsive behaviour. Although he remained restless and reluctant to study, he improved his skills and control with the help of a physiotherapist and a remedial teacher. As the parents gained insight into his problems he recovered confidence and motivation. His parents' self confidence also improved.

Clinical child psychology and adult psychology share a theoretical basis. Some of the differences in practice are illustrated by this case. The family is paramount when dealing with children. Therapy aims at effecting change in both the child and family members. M's parents were given insight by a detailed explanation of his behaviour. They also participated directly in his treatment. Educating others, especially parents and the health visitor, in specific therapy is a method used in clinical child psychology. Finally, an empirical approach to M's problem, leading to the participation of other expert agencies, was adopted—a facilitating role is often appropriate.

EMOTIONAL DISTURBANCE

Emotional disturbances included abnormal anxiety and abnormal fear; some were disguised as somatic complaints.

Example—E, a 6 year old girl, was frightened of rain and thunderstorms, tearful about going to bed, and irritable on wakening, and refused to go to school. The family consisted of mother, father, E, and brother aged 3. There were financial problems and marital conflict. Management included the participation of E's teacher, who agreed to reward E with praise and a moment of special attention when she arrived at school and a star on a chart when she did not make a fuss on hearing the sound of rain or thunder. Furthermore, the physical origins of thunderstorms were explained to her.

E's inappropriate behaviour had developed because of her unmet need for attention. There was some evidence that the father spent more time with his son than with E, but when this was discussed he agreed to give a "special"

time to E after the boy had gone to bed, which resulted in the bedtime problems and morning irritability diminishing. More sleep led to calmer behaviour, and she was able to talk about her fears. She was encouraged to draw and paint the good things that happen because of rain and was desensitised to thunderstorms by relaxation techniques while listening to a taperecorded thunderstorm. Thus her sleep improved, school attendance was fully restored, and family outings were not cancelled because of E's fears. Rewards, deconditioning, and discussion were used to help E.

DISORDERS OF FUNCTION

The second most common type of problem was disorders of function.

Example—J was introduced to the potty at 18 months; he was now 4 and refused to use either potty or toilet, which resulted in soiling and wetting by day and night. His mother reported conflict over his father's drinking habits during the first three years of J's life, but as this had now improved she was reluctant to connect the conflict with J's fear of evacuation, which she saw as deliberate defiance. As a temporary measure the resulting hard motions were relieved by laxatives, and more roughage was introduced in the diet. The role of anxiety in preventing J from "letting go" on his potty was explained to the parents, and he was encouraged to sit on the potty, even to urinate, to overcome his fear of squatting. Soiled pants, which were more common at first because of the softer stool, were changed without comment. He was given the potty at appropriate times, such as after meals, and rewarded when he sat and again later if he produced a stool. Within four weeks laxatives were no longer needed.

An explanation of the effect of anxiety and strategies to improve the parents' management were used to modify J's behaviour.

Discussion

The three main categories in the table show the most relevant features of each child's problems. Emotional disturbance and behaviour problems have been shown by multivariate analyses to exhibit different symptom patterns and may be considered as entities.[5] Emotional disturbance is characterised by fear, anxiety, misery, and somatic complaints.[6 7] Conduct disturbance is characterised by disobedience, disruptiveness, destructiveness, aggression, and often delinquent behaviour. This allows certain generalisations to be made. In emotional disorders the child is likely to suffer; in behavioural disturbance others suffer, especially the family. Broken homes, family hostility, rejection by the mother, vulnerable mothers, alcoholic parents, poor social conditions, and the presence of more than five children in the family are all associated with behavioural disturbance and delinquency. Emotional disturbances are more closely associated with maternal anxiety, parental overcontrol, reluctance of parents to separate—for example, not making babysitting arrangements—fear about the child playing outside, and frequent visits to the general practitioner for minor illnesses in the child.[8] In later life children with a behaviour disorder may conflict with the law, be alienated from their families, abuse drugs, and suffer marital breakdown.[9] Emotional disturbance in childhood (with the possible exception of obsessions) is compatible with stable adulthood.

Disorders of function may result from developmental delay, parental or child anxiety, or mismanagement. They respond to reward schedules and to therapy for dealing with anxiety when this is present.

The cases described were referred in a predominantly middle class area and are used as a basis for discussion. In a deprived area the relative size of categories would vary.

The general practitioner may refer to a clinical child psychologist or a child psychiatrist. What guidance can be given in making the choice? Gath has analysed the diagnoses made by general practitioners and psychiatrists in 47 referrals to a child psychiatric department,[10] and this may be compared with our series of referrals to a clinical child psychologist. Behaviour disorders and emotional problems were frequent referrals in both series. The general practitioner referred psychoses, mental subnormality, and organic mental disease to the child psychiatrist but not the clinical child psychologist.

Thus recognising obvious mental disease leads the general

practitioner to refer to the child psychiatrist. Even when the condition is less clearly based in disease the general practitioner may still refer to a child psychiatrist because this will share responsibility for diagnosis. In some cases the clinical child psychologist may prefer to obtain a paediatric or neurological opinion before dealing with the psychological aspects. In other cases direct referral from a general practitioner to a clinical child psychologist may be an advantage because psychologists have skills in developmental assessment and behavioural analysis. Furthermore, parents may find referral to a psychologist less threatening than referral to a psychiatrist.[11]

Clinical child psychology is cost effective. In the same study 45% would have otherwise been referred to child psychiatry and a further 30% treated by paediatricians, general practitioners, or clinical medical officers, each on a higher salary scale than a clinical child psychologist.

Primary referral to a clinical child psychologist may be most appropriate in behavioural problems, emotional disturbance, and disorders of function. Clinical psychologists may see children with psychological problems, including those associated with acute or chronic physical illness, at the request of a general practitioner or specialist. More important than who the child should first be referred to is that good communication between psychiatrist, psychologist, and general practitioner is maintained so that cross referral is facilitated whenever appropriate.

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Prevention for patients over 75: is it worth the bother?

DR STRINGFELLOW'S TEAM

Abstract

This paper describes the way in which one primary care team interpreted the evidence about screening and case finding in old age and introduced a simple system to test its feasibility. From the results of the study, which was conducted by members of the team without help from research workers, the team concluded that contact should be established with every person over the age of 75 every year but that it would continue to concentrate on managing problems known to it rather than searching for asymptomatic or unreported problems.

Introduction

The aging population in our practice poses a challenge to us. Our team therefore met to discuss screening and case finding as a means of preventing problems. A review of published work showed that screening—the search for asymptomatic disease—had not been effective but that case finding—identifying and managing previously unreported problems—had had some effect. We concluded that case finding and adequate follow up of problems identified had reduced mortality and improved the quality of life for patients in certain research studies, but there was little evidence that case finding would lower the rate of functional decline, the use of health services, or the probability of admission for long stay care.[1-3] Furthermore, the practices that had reported on their screening and case finding initiatives had a particular interest in the care of elderly people. We were obviously committed to improving the quality of our work with elderly people, but the practice has a varied population living in the city of Oxford and we wished to do this while also trying to improve the quality of our service to other groups of patients. Therefore, without undertaking a major project or a major reorientation of our work with elderly people, we decided on as simple an approach as possible. Such an approach might be relevant to other practices, which, like ours, have been daunted by the complexity of some of the systems for screening that have been published.

From the work done by the Medical Research Council unit in Aberdeen we concluded that it was not possible to identify a high risk group and therefore decided to follow up those people aged over 75 who had had no contact with the primary care team during one year.[4] There was evidence that non-consulters were a healthy group, and further evidence was published during our study, but we decided that our approach would be to visit all the people over 75 who had not made contact during one year.[5-7] We made this decision being aware that this was a much less elaborate system than that proposed by Barber and his colleagues in Glasgow, but we did not want to undertake an activity that would interfere with the clinical work with elderly people, or with the work with the many other patient groups who make demands on the primary care team.[8 9]

The emphasis was on detecting unreported problems—case finding—because we believed that there was no evidence that detecting asymptomatic disease—screening—was effective in elderly patients.[3]

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Method and results

We used a simple approach. The first step was to identify all the patients aged over 75. There were 229 of these, and a register was compiled using a 5 in × 3 in card box. When any person over 75 made contact with any member of the primary care team the card for that person was transferred from the register to another 5 in × 3 in card box by the practice manager who checked

off names on appointment and home visiting lists and asked the community nurses each week whom they had seen. We now use lists generated by computer, but the system of card boxes was satisfactory.

At the end of the year those patients who had not been seen were contacted by letter, and those who replied that they wished to be seen were visited at home. During these home visits the people were asked if they had developed any problems in the past year. A list of common functional problems was used for this.

At the end of the year 29 patients had not been seen, but two of these were seen in the first three days of the following year when the next phase of the project was being put into action. This left 27 (13·5%) of the original population who had not been seen, but three had moved and two had died, leaving only 22 (9·6%) who had not been seen during the preceding year and who were still on the practice list. Of these 22, four refused to see us, making it plain that they did not see any need for contact with a doctor; as one said: "No doctors please, we're OK." This group of people who had not made contact were fit and healthy. In fact some of the visits were difficult to arrange because the people were out so much, in more than one case "helping the elderly." Only seven lived alone and three of these had a telephone, leaving only four patients out of the 18 who neither lived with someone nor had access to a telephone to call for help if needed.

The table lists the problems that had developed, but which had not been reported, during the year. In addition, two patients reported new "aches and pains," one giddiness and the other a painful knee. We did not, therefore, find many unreported problems in the elderly patients who had not contacted the practice.

Unreported problems faced by elderly patients

Problem	No of patients who developed the problem during the preceding year without reporting it
Difficulty with shopping	0
Difficulty with dressing	0
Incontinence	0
Difficulty with bathing	7
Difficulty with sleeping	2
Visual failure	2
Difficulty with hearing	5

Discussion

This approach to improving the care of elderly patients is feasible for a practice with adequate ancillary staff. Furthermore, we had to cope with the retirement of one partner, the recruitment of a new partner, and the tragic death of the practice manager (BW), who had played a central part in setting up and running the system. Despite these difficulties we carried out the project at minimal cost. Only 22

letters were sent out to ask those who had not made contact if they would like a visit, no special clinics were arranged, and no special transport was required. The 18 visits were fitted into the routine work of the primary care team.

On face value the benefits were minimal, but we were impressed with the warmth with which we were received by the 18 patients who agreed to see us and believe that this type of case finding programme strengthens and improves the relationship between the primary care team and the patient. We also believe that this relationship is extremely important in encouraging early referral, compliance, and appropriate use of health services and thus concluded that the benefit made the exercise worth while.

We have agreed that we will continue with this simple scheme of contacting those who do not contact the practice during the year. We intend to use a similar type of checklist during the consultations that are initiated by elderly people to remind us to identify problems other than the presenting problem that may have arisen since the previous contact. The study, however, reinforced our view that most of our energy should be diverted to managing the problems—both acute and chronic diseases[10]—that elderly people present to us and that if we were to develop a more systematic approach to clinical practice we should concentrate our efforts on better management of chronic diseases rather than on an elaborate programme of case finding.

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100 YEARS AGO

Dr. Sieveking writes: The *Times* of January 19th contained a very interesting account of a tomb recently discovered in making excavations, on the Monte Testaccio, necessary for the construction of a large sewer, destined to discharge the contents of the drains and sewers of Rome into the Tiber, at a spot beyond the basilica of St. Paul's, outside the walls. The inscription on the tomb shows that it was the last resting-place of Sergius Sulpicius Galba, who is stated to have been consul in the year 144 B.C. The article in question concludes with the statement that "among other remains of the building of twenty centuries ago laid bare, the site of the college or guild of the faculty of medicine of that date, with an inscription bearing the names of thirty physicians, arranged in three columns, has been found." As a physician, I was naturally anxious to verify and investigate the matter, as we have not hitherto been acquainted with any institution in antiquity destined to promote the education or attend to the interests of the medical profession, analogous to our Colleges. By the aid of friends at the British Museum, and especially of Mr. Cecil Smith, I have been enabled to see the *Bullettino dell'Istituto Archeologico* of last June, which contains, in a paper by M. Henzen, a copy of the inscription referred to, with his interpretation of its meaning. It would appear, from his observations, that we have not to deal with a college or guild of medicine, but simply with a burial club. Moreover, he puts the date of this institution in the time of Hadrian, which would considerably reduce its antiquity. He says: "Collegia Salutaria in tempo dell' impero chiamavansi le corporazioni formate collo scopo di provvedere alla comune sepoltura di loro membri." The inscription runs as follows (all in capitals): "Numini. Domus. Aug. Sacrum. Æsculapio. et. Saluti. Aug. Collegium. Salutar. Loco. Assignato. ab. proc. patr. cæ. N. asolo. fecerunt. Felix. ver. Aspergus. Regianus. vindex. ver. Vilici. Prediorum. Galbanorum. et. pleps. Imm. Actatius. Januarius. Ulpius. Sextianus. Cluturius. Secundus." After this follow, in three columns, alphabetically arranged, fifty-three more names, among which are those of four women. Written out in full, I have Mr. Cecil Smith's sanction for saying that the inscription would run as follows: "Numini Domus Augustæ sacrum, Æscalapio et Saluti augustum Collegium salutare, loco assignato ab procuratore patrimonii Cæsaris nostri, a solo fecerunt, Felix verna, Aspergus Regianus, Vindex verna, Vilici prediorum Galbanorum et plebs, immunes." The word "immunes," according to Mr. Cecil Smith's view as here applied to the three names which follow, means "without charge." They would therefore have been honorary members, while the remaining fifty-three names, arranged in columns, would together make up the "plebs," or rank and file of the society. (*British Medical Journal* 1886;i:358.)