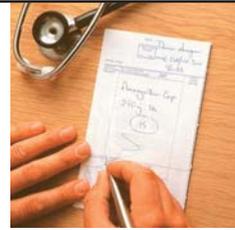


Referring to a child psychiatrist



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BACKGROUND

Child psychiatry is a highly specialised practice and many general practitioners are uncertain how to manage a child who might require such intervention.

OBJECTIVE

This article provides some guidelines regarding referral and ongoing collaboration, but it is important to remember that each child psychiatrist may have their own style of practice.

DISCUSSION

Most child psychiatrists work with the range of childhood ages from primary and secondary school age children through to youth and early adulthood. It is essential that the GP take a medical history and examination before referral. Referral should be specific.

What presenting problems should be referred to a child psychiatrist?

Child psychiatrists are trained in child development and can advise on the range of emotional, behavioural, and relationship disorders in infants, children and adolescents. These include:

- anxiety (including separation anxiety), school refusal, phobias, obsessive compulsive symptoms, post-traumatic symptoms
- depression and other mood disturbances
- behavioural problems including disorganised or aggressive behaviour
- eating disorders
- parent-infant relationship difficulties
- peer relationship difficulties
- self harm
- hallucinations, delusions, or other unusual or bizarre behaviours, and
- physical symptoms for which an organic explanation cannot be found, and where there are features that suggest a significant emotional contribution.

What age range of children do child psychiatrists see?

Most child psychiatrists work with the range of childhood ages, from primary and sec-

ondary school age children through to youth and early adulthood. Many child psychiatrists also practise general adult psychiatry, adult psychotherapy, family therapy, or couple therapy. Many child psychiatrists can assist with infant problems, working with the parents and infant together.

The referral letter

The general practitioner should not refer solely on the basis of the parental description, but should interview the child. An older child or adolescent should be given the opportunity to speak without the parent present.

A standard child psychiatric interview includes a separate interview of the parents. Medicare requires the fee to be charged to the patient who is present in the room. Therefore it is helpful to refer 'the child and his/her family' (*Table 1*). It is helpful if the GP is specific about what he or she is actually requesting. Typically this is 'for opinion and management'. If the GP would like the psychiatrist to confer before proceeding with treatment, it would be best to specify this in the referral letter.

Physical examination and tests

It is essential that before every child psychi-

atric referral, the GP take a medical history and examination as indicated (*Table 1*). This is necessary because:

- some physical conditions can cause psychiatric syndromes
- some psychiatric illness may be associated with physical symptoms (eg. eating disorders)
- if the patient is prescribed medication, it is helpful to have a record of baseline vital signs for comparison in case of side effects
- if the patient has a history of significant illness or physical disability, these should be included in the psychiatric formulation of the whole child.

Significant positive or negative findings should be noted in the referral.

Medication

Some GPs begin child or adolescent patients on psychiatric medication at the time of making the referral (*Table 1*). This could preempt the specialist opinion that may differ from the GP's. Recent publicity in the professional and lay press has highlighted the risks of using psychotropics in children, especially selective serotonin reuptake inhibitors (SSRIs). The prescription of medication by the GP may close the parents' minds to considering the role of psychological issues, family interactions, and development in the child's symptoms.

If a patient is already medicated when he or she attends the psychiatrist, then it is not possible to observe the presenting symptoms accurately. Prescription by the GP may be indicated if an appointment with the psychiatrist is not available within a short time and there is major risk (eg. a suicidal or psychotic adolescent).

When the parents are separated or separating

Most child psychiatrists insist on the involvement of both parents in the assessment. In the case of separated parents, this may cause difficulty. In my practice, I require at the very least written consent from the other parent and preferably the other parent's participation.

Table 1. Referral tips

Before referring a child to a child psychiatrist:

- take the child's medical history and perform a general medical examination
- order laboratory tests only if indicated by history and examination
- ensure the parents understand and agree to the referral
- do not prescribe psychiatric medication unless there is major risk and an urgent specialist appointment is not available

The referral letter should include:

- the GP's provider number
- a brief description of the presenting problem
- relevant positives and negatives in the medical examination of the child
- any comments from the GP's experience of the family and parental functioning
- summary of significant current and past physical health of the patient
- family psychiatric history known to the GP
- copies of any previous specialist medical assessments of the child
- whether the psychiatrist is being asked to take on treatment
- referral of the child and his/her family to cover separate parental consultations
- 'indefinite' referral if appropriate

After referral:

- follow up to ensure family attended
- discuss any parental concerns about the assessment and treatment
- review medication side effects and compliance (if relevant)

The separation of some parents may involve major conflict. Children in this situation are at risk and often display emotional and behavioural problems. Unfortunately, it is very difficult to engage such children in psychiatric treatment and to provide benefit if there is major ongoing parental conflict. The parental conflict may interfere with their support of the psychiatric intervention.

It must be emphasised to the parents that the child cannot be assessed and helped until the parental situation is contained. An assessment of the child will be skewed by the ongoing conflict and will not give an accurate measure of the child's underlying development.

What if the parents are unwilling?

Sometimes a GP may be very concerned about a child psychiatric problem, but the parents minimise the child's problems. The GP may induce the parents to consult with a

child psychiatrist hoping that the psychiatrist will help the parents to recognise the seriousness of the problem. If the family do not understand the reason for the referral, if they actively disagree with the reasons, or if they have questions or doubts about the referral, then they are unlikely to follow through with the referral or may drop out before the psychiatric assessment is completed.

The GP's discussion and explanation to the family about the referral is useful to prepare the family for their first visit to the psychiatrist. If the parents remain unwilling, then it may be useful for the GP to explain the reasons for his/her concern, and then arrange a review appointment with the GP in a couple of weeks. This may give the parents time to consider the child's problems further. This process may need to be repeated to gradually gain the parent's insight and commitment to cooperating with specialist intervention.

What to tell the family about a child psychiatric assessment

There are a variety of assessment structures used by child psychiatrists, but a typical program includes:

- family interview including all members of the household
- child interview
- parent interview
- information from the school
- obtaining results of any past child mental health and medical interventions, and
- feedback interview with child and parents, discussing the psychiatrist's formulation and treatment plan.

A variety of treatments are available depending on the diagnostic formulation, but may include:

- individual child psychotherapy
- family therapy
- parent therapy
- child group therapy
- drug therapy
- referral to a child psychiatric day program
- child inpatient admission, and
- further investigation (eg. referral to a neurologist, paediatrician, child psychologist for intellectual testing, child psychiatric developmental assessment program).

After referral

It might be helpful for the GP to indicate in the referral how much he/she wants to be involved in the ongoing management of the child. Parents may have concerns about their child's psychotherapy and may raise them with the GP rather than the psychiatrist. The GP may therefore provide a useful role in supporting the child's psychotherapy.

Often child psychiatrists prefer to separate the child psychotherapy and the parental therapy between two colleagues. A child feels less inhibited about 'opening up' if he or she knows that the psychiatrist is not closely involved in discussion with the parents. However, parents may feel left out of the process and complain to the GP. The GP can reassure the parents of the benefit to their child of this approach. If they are not satisfied, then it may be helpful for the

psychiatrist to offer a review appointment with the parents regarding their child's psychotherapy.

Often in a child's therapy, he or she may go through a stage of reluctance about attending. Sometimes the child is testing how committed the parents are to ensuring the child's recovery. Sometimes the child may be exploring uncomfortable emotions during the therapy and therefore finding therapy difficult. Some children with a history of attachment disruption may be anxious that they are becoming too attached to the therapist and are afraid they will be abandoned. The GP (and the psychiatrist) can reassure parents that if they are accepting, supportive, but firmly maintain the child's attendance, that the child will work through this stage and make significant therapeutic gains.

If medication has been prescribed, the psychiatrist may prefer that the GP review medication as this could interfere with the flow of psychotherapy.

Conflict of interest: none declared.

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