

Child Psychiatric Consultations in a General Hospital

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ABSTRACT

Background: The referral pattern of child psychiatry was reviewed over a period of 3 years. The setting was a local general hospital with in-patient and out-patient adult psychiatric services. The cases studied were from out-patient based services rendered for children.

Objective: To draw a comparison between trends of referral from a study conducted locally in 1984 in a child guidance clinic.

Methods: A questionnaire was used to collect demographic information for children below 16 years. Medical records of patients seen between January 1992 and December 1994 were analysed.

Results: In our study, parental referrals topped the list of source of referrals compared to referrals from school health service in the study conducted in 1984. The conditions commonly seen remained the same, namely mental retardation, neurosis and adjustment reaction.

Conclusion: Children were referred according to parent tolerance and acceptance of psychiatric help as well as behaviour.

Keywords: child psychiatry, pattern of referral

INTRODUCTION

Three previous studies examining the types of child psychiatric referrals were undertaken at the Child Psychiatric Clinic (CPC) based at the Institute of Health. The first of these three studies was a survey of child guidance service published in 1972⁽¹⁾. The second study was a survey of a year's new patients conducted in 1975⁽²⁾. These were conducted with a view of making a comparative analysis and the third study was carried out 10 years later by Ko et al⁽³⁾.

With the opening of the National University Hospital (NUH) a decade ago, the Department of Psychological Medicine was established in a general hospital setting. This department provides psychiatric liaison services to our medical as well as surgical colleagues in the hospital. In the process, the child psychiatric liaison service was introduced to meet the rising needs of our paediatricians. However, the types of child psychiatric cases managed by the Department have never been examined in a systematic way. In this paper, we present the findings of our study and compare our results with previous published studies. The results

of our study are also important in the planning of future child psychiatric services in the hospital⁽⁴⁾.

MATERIALS AND METHODS

Our sample consists of 100 consecutive new cases referred to the Department of Psychological Medicine for psychiatric assessments between 1992 and 1994. For the purpose of this study, only children below the age of 16 were classified as child cases. A questionnaire was used to collect demographic information systematically. The hospital case records of all these patients were traced and relevant clinical data, developmental history, family history and management data were extracted from the records. All diagnoses were based on the 9th Edition of the World Health Organisation International Classification for Disease (1978). The collected data were then analysed using the Statistical Package for the Social Sciences (SPSS).

RESULTS

The demographic profiles of these patients are shown in Table I. Our data showed that the majority of patients (28%) were referred by their parents to our services. This contrasted sharply to the majority of cases being referred from the school health services in a local study conducted in 1985. Of the 100 patients, 53% were boys and 47% were girls.

In terms of age group, most of our cases ranged between the ages of 13 years and 16 years whilst CPC attended to the majority of children with ages ranging between 7 and 12 years. This is perhaps a reflection of our sources of referral. We attend to teenagers and those who are more likely to utilise general hospital services. In contrast, CPC gets their referral mainly from schools for the 1-6 years age group, there is no difference between the two centres. There were 85% Chinese and 7% Indian patients. In comparison to our general population statistics where the Chinese constitute 75%, Indians make up 5%. Chinese and Indians were over-represented, while the Malays were under-represented. With respect to ethnicity, there were no changes seen in the percentages of cases seen in 1975 and 1985 respectively. The Chinese constituted about three quarters of the cases, the Malays and Indians about one-tenth each, while the other ethnic groups made up the rest.

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Table II tabulates the different diagnoses of our patients. Our study included children assessed by the psychologist for their intelligence quotient (IQ). In the category of others, cases included children who were diagnosed to have bilateral moderate sensorineural hearing loss, temporal lobe tumour, epileptic psychosis and SLE psychosis. In one case of a girl diagnosed with systemic lupus erythematosus (SLE) she was referred by the paediatric department for co-management with the department of psychological medicine as she presented with paranoid delusions and hallucinations. In another case, a girl who presented with vocal tics, was later diagnosed to have epilepsy.

DISCUSSION

The different demographic profiles of our patients compared to that of CPC is the most interesting finding in this paper. The difference reflects the nature of the practice in the two settings. Whilst the Child Psychiatric Clinic works hand in hand with the school health service, the division for child psychiatry in National University Hospital serves as a subunit of the Department of Psychological Medicine. It would be fair to say that the bulk of child psychiatry is handled by the child psychiatric clinic and what we serve is as an adjunct to this service. As we provide a liaison service to our paediatric colleagues, we do not see referrals from the court, although we do see referrals from the social services from time to time. In comparison, a small percentage of cases was referred from the Ministry of Community Development and from the Juvenile Court in the previous two studies (7% in 1975, 1.9% in 1985).

In agreement with most published studies, we also see more males than females in our clinic. The overall sex ratio is 1.13: 1. The Isle of Wight study by Rutter et al⁽⁵⁾ covering 10 and 11-year-old children showed twice as many boys as there were girls. Leslie⁽⁶⁾, who studied 13 to 14-year-olds in Blackburn also demonstrated a higher prevalence of psychiatric disorders in boys (20.8%) and in girls (13.6%). In our study, there were more males (1.85:1) below 12 years old, and less males (0.59:1) above 12 years old.

With regards to the diagnoses, again there is a difference between the type of cases that were treated in CPC compared to those treated by us in NUH. Naturally, we saw a greater percentage of children diagnosed to have physical conditions. This is in keeping with our liaison role in a general hospital. In addition, similar to the study in 1989, there were more "non-psychotic" cases that were referred.

The rate of psychiatric disorder being higher in children with physical disease particularly neurological disorder is not a new finding⁽⁷⁾. It is important to point out that the different demographic information reflects the nature and type of practice employed. Recognising this trend will help in planning our services differently. For example, most of our referrals are parental-referred, hence it is important to make known our services to parents so that those children who require consultation in a general hospital setting can be referred appropriately. The fact that most of the children we see are parental-referred may mean that it may be face saving to see the child's problem "medicalised".

Informing our fellow colleagues that there is such a service available in a general hospital would further help in unwarranted investigations and hospitalisations. This would serve as a provision for continuity of care.

In conclusion, this study did not set out to determine the aetiological factors in the development of psychiatric disorder. The aim was to establish a pattern of referral with view to

Table I – Demographic profiles of patients

	Present study 1992-4 (n=100)		Ko et al 1984 (n=885)	
		%	No.	%
1. Sources of referral				
Self-referral	28		0	0
Hospital specialists	39		139	15.7
Polyclinics	0		181	20.5
Private practitioners	24		113	12.8
School health service/Schools	0		362	40.9
MCD/Juvenile Court	0		17	1.9
Others	9		73	8.2
2. Sex		%		%
Male	53		61.7	
Female	47		38.3	
3. Age group		%		%
1 – 6	23		22.2	
7 – 12	32		47.6	
13 – 16	45		30.2	
4. Ethnicity		%		%
Chinese	85		77	
Malay	7		10	
Indian	7		9	
Others	1		4	

Table II – The different diagnoses of patients

	Ko et al (1985)		Present study (n=100)	
	No.	%	No.	%
Normal variation	119	13.4		5
Adjustment reaction	180	20.4		11
Developmental disorder	39	4.4		3
Neurosis	84	9.5		13
Conduct disorder	94	10.6		7
Personality disorder	7	0.8		1
Psychomatic disorder	6	0.7		1
Schizophrenia	35	4.0		7
Affective disorder	7	0.8		3
Mental retardation	173	19.5		15
Disturbances of emotions	31	3.5		11
Special syndrome	67	7.6		7
Others	11	1.2		14
Unknown	32	3.5		1

planning of services. Currently, the Division of Child Psychiatry participates in the provision of running of "children clinics" fortnightly, attending to children and their parents referred by our paediatric colleagues. In addition, we also respond to inter-departmental consults in query to the possibility of a child psychiatric case. It certainly cannot be claimed that adequate psychiatric help in childhood will prevent future mental illness nor can it be said that psychiatric help alone will solve all difficulties of these children.

Further research is needed into the cause of psychiatric disorder, paying attention to intrafamilial, environmental and social factors. To an extent, children are referred according to parent tolerance and acceptance of the idea of psychiatric help as well as behaviour⁽⁷⁾.

REFERENCES

1. Long FY, Oon PK, Lee MM. Two years' experience of child guidance service in Singapore. *Singapore Med J* 1972; 13:245-8.
2. Goh CW, Bose P. Child psychiatric problems in Singapore: A retrospective study of a year's new patients. *Singapore Med J* 1980; 21:467-73.
3. Ko SM, Goh CW, Tan SK, Chan S. A comparative study of new cases seen at the Child Psychiatric Clinic in 1975 and 1985. *Singapore Med J* 1989; 30:553-6.
4. Wong CK. Child Psychiatry in Hong Kong: A retrospective study. *J Hong Kong Med Assoc* 1988; 40:40-9.
5. Rutter ML, Tizard & Whitmore K. *Education, Health and Behaviour*. London: Longman, 1970.
6. Leslie SA. Psychiatric disorders in the young adolescents of an industrial town. *Br J Psychiat* 1974; 125:113-24.
7. Bailiew D, Carralda ME. Referral to Child Psychiatry: Parent and Doctor Motives and Expectations. *J Child Psychol Psychiat* 1989:449-58.