'It must be because ...'

Non-biological care and mental health

Part III. Who refers – and why?

Cas O'Neill and Deborah Absler

This article, the final in a series of three, looks at how and why children are referred for psychiatric help, and then presents an analysis of referrals which occurred during the period, 1.7.1991 - 30.6.1993, at Alfred Child and Adolescent Mental Health Service in Melbourne.

Analysis of the referral sources for two groups of children (those who had experienced non-biological care and those who had not) showed very different patterns, the implications of which are discussed. In contrast, analysis of the presenting problems showed that the difference between the two groups of children was not as marked as had been expected. Possible explanations for this, involving systemic issues, are explored.

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This is the final article in a series which looks at the relationship between non-biological care (adoption, permanent care, foster care and residential care) and referral to mental health facilities. The first article in the series reviewed the literature relating to this issue (O'Neill & Absler, 1998), while the second reported on an analysis of referrals to a Victorian Child and Adolescent Mental Health Service, related to Victorian population statistics (O'Neill, 1999).

This article looks at how and why children (in general, as well as the non-biological care group) are referred for psychiatric help and then presents an analysis of referrals which occurred at Alfred Child and Adolescent Mental Health Service during the study period, 1.7.1991 - 30.6.1993.

The questions which informed this phase of the study were:

- What factors contribute to whether children with mental health problems are referred to child psychiatric clinics?
- Are these factors different for children who have experienced non-biological care compared with children who have not had this experience?
- Are children with particular kinds of mental health problems more likely to be referred than others?
- Who refers?
- What factors influence who makes the referral?

The Child and Adolescent Mental Health Services Draft Policy Statement (Department of Health and Community Services, 1994) states:

> ... epidemiological studies consistently report a point prevalence of psychiatric disorder of 10 - 20 % among children and adolescents in Australian and other Westernised urban communities. Approximately 3-5% of these children are estimated to have severe disorders which require the specialist treatment provided by child psychiatric services. (Yet) of those 3-5% who require specialist services, much less than half end up receiving them.

REFERRALS OF CHILDREN IN THE GENERAL POPULATION

In their search of the literature, Marks et al (1981) concluded that

> ... very little work has been done exploring why professionals working with children perceive them as psychiatrically disturbed and in need of help, and how professionals chose the agencies to which they referred children (p. 224).

They cite an earlier study by Stocking et al (1970, cited in Marks et al, 1981) which demonstrated that, although 64% of the children in paediatric wards were considered to be sufficiently disturbed to need psychiatric consultation, only 17% of the children were actually referred to a psychiatrist.

In Marks et al's study (1981) they found that children presenting with neurotic disorders evoked the least concern by non mental health professionals. The children who *did* cause most concern were those from families with multiple problems. Marks et al concluded that this finding suggested that child psychiatry services were used for referral when the agencies

involved felt overwhelmed by the complexity and severity of the problem.

Bailey and Garralda (1989) studied a cohort of children who were referred to child psychiatric clinics by their parents, on the advice of their general practitioners (GPs). They analysed general practitioner and parental attitudes towards the referral and found that the issues that led parents to attend GPs' surgeries were not necessarily related to a worsening of the child's problem, but more to a sense that the parent, or the school, had reached the point where they felt unable to cope with the child's disturbance. A similar finding also emerged in a study by Weisz et al (1988, cited in Weisz & Weiss, 1991) which suggested that parental judgements about how serious and how much in need of treatment a problem is, are related to how troubling or bothersome the behaviour is to themselves or others.

In Bailey and Garralda's study, the parents had specifically attended the GP's surgery to request help for their children. However, other studies cited by Bailey and Garralda suggest that psychiatrically disturbed children are more likely to initially attend surgeries for somatic complaints than others (Campion & Gabriel, 1984; Garralda & Bailey, 1986; Starfield et al, 1985, all cited in Bailey & Garralda, 1989).

In their discussion of the factors which contribute to the 'referability' of child clinical problems, Weisz and Weiss (1991) state:

> Because children rarely consider themselves 'psychologically disturbed' and rarely refer themselves for treatment, it is generally adults in a particular child's society who determine whether that child's behaviour constitutes 'psychopathology' and whether it warrants intervention. Child problems that adults do not consider serious are less likely to receive clinical attention, even if they are very distressing to the child. Child problems that adults *do* consider serious may well lead to treatment even if they are not distressing to the child (p. 266).

Weisz and Weiss (1991) hypothesised that the referability of different problems would differ as a function of the weighting of various characteristics of the problem, for example, whether it was one or other of the two most frequently identified empirically derived syndromes: *over-controlled problems* (eg, anxiety, somatic problems, social withdrawal), or *under-controlled problems* (eg, disobedience, fighting, stealing). These two 'broadband' syndromes have emerged from more than a dozen independent factor analytic studies of children's behaviour problems (Achenbach & Edelbrock 1978, cited in Weisz & Weiss, 1991). In addition, referability of the *same* problem may differ as a function of child characteristics (eg, the gender of the child who manifests the problem), or of the culture in which the problem occurs (Lambert et al, 1989; Weisz & Weiss, 1991).

... having been identified in a given setting, children with psychiatric difficulties are channelled along pathways more dependent on the links of the professional concerned, than the nature of the child's disturbance and therapeutic need (Marks et al 1981).

In a South Australian study, Sawyer et al (1990) also found that children with different types of emotional and behavioural disorders attended different types of services. Children with what they described as 'externalizing problems', that is, children whose problems are predominantly those of aggressive, antisocial or under-controlled behaviour, are most likely to be referred to community health centres, school guidance officers and to psychiatrists, psychologists or social workers in private practice.

In contrast, children with 'internalizing disorders', exhibiting predominantly fearful, inhibited or over-controlled behaviour problems, were more likely to be referred to general practitioners and hospital services. Sawyer et al (1990) comment that:

> A striking finding from this study was how frequently advice was sought about children regardless of whether or not they were identified as cases.

Advice had been sought for 47% of these children from general practitioners, which:

> ... emphasizes the potentially important role for general practitioners in the early identification and management of children with emotional and behavioural disorders (p. 329).

A later study by Sawyer et al (1992) found that children referred to child mental health clinics are more likely to be those who have problems which are apparent to parents and teachers, particularly problems which are irritating or annoying. In particular, clinic-referred children appear to be characterised by parent reports which emphasize the presence of externalizing problems in children[1].

Godfrey (1995), in summarising the results of other research, found that receipt of treatment is associated with the severity of the disturbance, higher parental income and educational level, and rural rather than urban residence (Graham & Rutter, 1973; Langer et al, 1974; Rutter et al, 1975, cited in Godfrey, 1995). In common with Sawyer et al's (1990; 1992) research, Godfrey also cited research which showed that children with emotional disorders may be less likely to receive help than those with conduct disorders (Anderson et al, 1987, cited in Godfrey, 1995).

Godfrey's study, undertaken in the UK, analysed the pathways to care which preceded 46 children receiving treatment at a child and adolescent outpatient psychiatric centre, that is, the sequence of contacts with professionals or agencies prior to referral. The results indicated that the first point of contact

[1] It is interesting to note that this study found that, while children in the community reported more externalizing and internalizing problems than did their parents, clinic-referred children reported fewer externalizing, but more internalizing, problems than their parents.

was the general practitioner in nearly 50% of cases, school staff in nearly one-third and the health visitor in one-fifth (especially for younger children).

In an earlier study which analyses pathways to care, Marks et al (1981) suggest that, having been identified in a given setting, children with psychiatric difficulties are channelled along pathways more dependent on the links of the professional concerned, than the nature of the child's disturbance and therapeutic need.

REFERRALS OF CHILDREN WHO HAVE EXPERIENCED NON-BIOLOGICAL CARE

Research which focusses on referrals of children who have experienced non-biological care tends to echo the findings cited above, that children with externalizing problems are more apparent within mental health clinics.

Research undertaken by Verhulst et al (1990) focussed on the profile of problem behaviours in fourteen year old international adoptees. They compared the information provided by parents using the Achenbach Child Behaviour Checklist and the clinical diagnosis which the child psychiatrist gave the child, based on data received from the child, parents and teachers.

These authors found that the prevalence rate of psychiatric disorder for the fourteen year old international adoptees was somewhat higher than for general population samples, particularly for boys, who were more likely to exhibit disruptive behaviour disorders (in contrast to the girls, who were more likely to show emotional or mixed emotional/disruptive behavioural disorders in the group of those with psychiatric diagnoses).

In their review of studies which had taken place in the 1960s and 1970s in the United Kingdom and the United States, Howe and Hinings (1987) found that children adopted by non-relatives were referred to child psychiatric settings at a higher rate than for the general population and that the rate of referral increased with the onset of puberty.

In their analysis of 1520 new referrals to a Child and Family Centre, Howe and Hinings found that the rate of referral for adopted children was approximately twice that for the general population. All the adopted children aged nine years and under were referred because their parents found them difficult to control, while the majority of the children aged ten and over 'behaved in ways that were unacceptable to their parents as well as the wider community' (Howe & Hinings, 1987, p. 46).

Although Howe and Hinings acknowledge that the range of symptoms in the adopted children is broadly typical for all children referred to child guidance clinics, they found that there was a slight bias towards 'delinquent' behaviour, the 'under-controlled problems' that Weisz and Weiss (1991) identified. Howe and Hinings also state that:

> the adoptive dimension did seem to feature in the minds of referrers, particularly when that person was a third party. Referral letters from GPs invariably began 'Jason is the adopted son of Mr and Mrs ...' (Howe & Hinings, 1987, p. 46).

Table I. Sources of referral

REFERRAL SOURCES	GROUP 1		GROUP 2		Fisher's
	Number	%	Number	%	Test
Parents	160	37.2%	17[1]	16.6%	<0.001
Relatives	-	-	3[2]	3.0%	.002
Teachers	71	16.5%	3	3.0%	0.2
School Support Services	17	4.0%	2	2.0%	>0.9
Hospital/Allied Health[3]	65	15.2%	9	8.8%	0.7
General Practitioners	33	7.7%	4	3.9%	>0.9
Parents 'on Advice' from School/Creche	17	4.0%	1	1.0%	>0.9
Parents 'on Advice' from Doctor/Counsellor	6	1.4%	1	1.0%	>0.9
Parents 'on Advice' from Friend	5	1.2%	1	1.0%	>0.9
Dept. of Human Services	17	4.0%	29	28.4%	<0.001
Non-Government Organisations (NGOs)	11	2.6%	18	17.6%	<0.001
Dual Parent/School	8	1.9%	-		0.9
Dual Parent/Agency[4]	1	0.2%	4	3.9%	0.001
Dual Agencies[5]	7	1.6%	6	5.8%	0.003
Child Care/Pre-School	10	2.3%	1	1.0%	>0.9
Police/Court	1	0.2%	3	3.0%	0.009
TOTAL	**429**	**100%**	**102**	**100%**	

[1] For the children who had lived away from their biological parents, 14 were referred by their biological parents, 2 were referred by foster parents and 1 was referred by the adoptive father.

[2] Two aunts and 1 maternal grandmother.

[3] Includes paediatricians, psychiatrists, speech therapists, counsellors.

[4] Either DHS or NGOs

[5] Usually a combination of DHS and NGOs

THE FINAL STAGE OF THE RESEARCH - REFERRAL SOURCES AND PRESENTING PROBLEMS

The final phase of the research described in the second article in this series involved an analysis of the referral sources and presenting problems for the children referred to Alfred Child and Adolescent Mental Health Service (Alfred CAMHS) between 1.7.1991 and 30.6.1993. Group 1 are the children who have continuously lived with their biological parents, while Group 2 are the children who have lived apart from their biological parents (usually for an extended period of time). Of the original 604 new case registrations on which information was received for this study, sources of referral were available for 531 registrations (429 in Group 1 and 102 in Group 2).

Table I shows the referral sources for Groups 1 and 2. Using parents as the baseline category, each other category was compared to the baseline in turn, using Fisher's exact test. Fisher's exact test was also used to compare the two groups with respect to the percentages referred by parents.

The differences between Groups 1 and 2 are statistically significant in the categories of referrals by parents, relatives, Department of Human Services, non-government organisations, dual parent/agency, dual agencies and police/Court. As could be expected, the overall referral patterns for Groups 1 and 2 are quite different, with over 50% of the Group 2 children (compared to under 10% of the Group 1 children) being referred to Alfred CAMHS by Victoria's Department of Human Services, non-Government agencies or a combination of these. We were nevertheless surprised that such a significant proportion of the Group 2 children were referred by their biological parents.

Table II shows the presenting problems for the two groups – these have been divided into externalizing and internalizing problems, as described in the review of literature, in addition to other categories (where externalizing and internalizing factors had not been recorded). Of the original 604 new case registrations on which information was received for this study, presenting problems were available for 568 registrations (467 in Group 1 and 101 in Group 2). Using externalizing problems as the baseline category, each other category has been compared to the baseline in turn, using Fisher's exact test. Fisher's exact test was also used to compare the two groups with respect to the percentages presenting with externalizing problems.

Differences between Groups 1 and 2 are statistically significant in the categories of learning disability, developmental problems, sexual abuse and neglect/ maltreatment.

One of the issues we were confronted with in interpreting the data in Table II was the apparent difference in the way in which the therapists recorded the presenting problems for the two groups, as well as the fact that some therapists gave far more detail and/or clearer information than others. It was also interesting to note that the task of determining which of the presenting problems were included in the externalizing categories and which in the internalizing categories, was far more clearly communicated by staff for children in Group 2 than in Group 1.

This may reflect the different entry pathways that children referred to Alfred CAMHS undertake (as outlined in Article I in this series). As the referral for a child in Group 2 is likely to have involved considerable contact between the Alfred CAMHS intake staff and the referring worker (or workers), including case consultation meetings and written referrals, by the time the child is seen for an assessment by an Alfred CAMHS staff member, detailed information about the child's areas of difficulty will already be known. This information will not consist of the raw referral data, but will already have been processed and tentatively placed in a diagnostic category by the worker having contact with the referring parties.

However, children in Group 1 are more likely to have been referred by their parents, or professionals acting on behalf of information provided by the parents, and the referral information is therefore more likely to be couched in generalised and non technical language. It will represent how the parents or

Table II. Presenting problems

PRESENTING PROBLEMS	GROUP 1		GROUP 2		Fisher's Test
	Number	%	Number	%	
Externalizing	139	29.8%	37	36.6%	0.2
Internalizing	165	35.3%	28	27.8%	0.13
Internalizing/ Externalizing	48	10.3%	12	11.9%	>0.9
Learning Disability	67	14.4%	3	2.9%	0.001
Developmental Problems	28	6.0%	0		0.005
Sexual Abuse	6	1.3%	9	8.9%	0.004
Autism	5	1.1%	1	1.0%	>0.9
Speech/Language	3	0.6%	0		>0.9
Intellectual Disability	2	0.4%	2	2.0%	0.4
Psychosis/ Schizophrenia	2	0.4%	2	2.0%	0.4
Child Abuse	2	0.4%	0		>0.9
Neglect/Maltreatment	0		5	4.9%	0.001
Parental Mental Illness	0		2	2.0%	0.09
TOTAL	**467**	**100%**	**101**	**100%**	

community professional, rather than a mental health practitioner, frame the problem.

The issue of who provides information at the point of referral and how they are likely to frame the problem is also relevant when interpreting the larger number of children in Group 1 than in Group 2 who were referred because of learning disabilities and developmental problems. What also needs to be taken into account when interpreting these figures is that two of the specialist services provided by Alfred CAMHS are a specific Learning Difficulties Clinic and a Developmental Assessment and Management Program which have their own intake procedures and entry point separate to the general clinic population.

At the point of entry, the information given to staff members, usually provided by parents, includes the presenting problems related to these areas. In some cases, parents may feel more comfortable in perceiving that their child has primarily a learning or developmental problem, rather than a mental health problem. However, by the completion of the assessment process, it would be expected that a number of these children may be seen as having either primary or secondary difficulties that would fit the externalizing and internalizing problem categories.

Both these specialist services have very long waiting lists. Group 2 children, who are at least as likely as Group 1 children to have significant areas of difficulties related to their learning and development, are nevertheless less likely to be seen through these programs, due to placement uncertainty and movement.

Group 2 children are therefore more likely to enter the service on the basis of their emotional and behavioural presentation, with learning and developmental difficulties becoming apparent through the assessment process, subsequently leading to a referral to Alfred CAMHS specialist staff. In summary, because of the different processes the Groups 1 and 2 children have taken to enter Alfred CAMHS, the amount and type of information known to the assessing staff will be different and will account for the different results recorded in Table II.

However, it is also possible that, as the clinicians knew that the emphasis of the research was children who had experienced non-biological care, they were more careful in recording the presenting problems for this group of children. This explanation is validated by the discrepancy between the details recorded for Groups 1 and 2. For example, presenting problems were recorded in 467 of Group 1, yet referrers were only recorded in 429 of the same group. This is probably because the clinicians would have known the presenting problems without reference to the file, but may have needed to consult the file for referral sources. In contrast, for Group 2, presenting problems and referrers were recorded in roughly equal numbers, indicating that the clinicians probably consulted the files.

... parents may feel more comfortable in perceiving that their child has primarily a learning or developmental problem, rather than a mental health problem.

DISCUSSION

In this research the answer to 'who refers?' differs markedly depending on whether the child or adolescent is or is not living with biological parents. Significant others play an important role in all referrals, whether or not the child has lived continuously with biological parents. However, referrers for Groups 1 and 2 differ markedly. If the child lives with biological parents, the primary circle of professionals involved in the child's life – teachers, GPs and other health professionals – are likely to directly or jointly refer or 'advise' the family to seek help. This may or may not have a quasi involuntary aspect to it such as 'if your child does not receive treatment we may have to review his or her presence in this school next term'.

However, when the child lives in non-biological care, the circle of services which are involved in the child's life comes from another layer of service providers, government and non-government agencies, which include both voluntary and involuntary services. While this is logical, given that these agencies have direct responsibility for the children, there are nevertheless questions which arise from this finding:

- Does it mean that the primary support network (of teachers, medical professionals, etc) does not take an active role in referring these children or does the primary support network suggest referral to the involuntary sector, which then undertakes the referral?
- Are members of the primary support network less likely to refer because they think someone else has responsibility for these children?
- Is there a difference between how serious a problem needs to be before an involuntary service will refer a child, compared to the primary level of professionals?
- Are children referred by parents, school, GP or health professionals more likely to be accepted or referred elsewhere (for example, within the private system) than children who are currently removed from their parents?
- Are different questions asked by the mental health professionals about each group of children?

The referral of children living with their biological families (Group 1) may appear to be more straightforward to the child and adolescent mental health service for two central reasons. Firstly, it is perceived that the referrers (either the child's parents or GP or teacher) are requesting only a clinical service while, in contrast, for children in non-biological care (Group 2), a referral may also involve a range of diverse and complex issues related to the child's future.

Secondly, with children in Group 1, 'ownership' of the child's problems remains very clearly with the child's parents and referrers. The medical model of a GP referring for a specialist opinion operates very strongly when the referring party exists within the child's

primary support network. The rules appear clear and all parties operate by them.

However, for children in Group 2, these rules are not necessarily shared, as referring agencies operate under different constraints and mandates. The situation may thus occur that, by the time the assessment at the child and adolescent mental health service has been completed, the referring agency may have passed its legally sanctioned period of time to be involved with the family and is keen for case management responsibility to be handed over to another service.

There may also be very different expectations by the referring agency and the child and adolescent mental health service about where the boundary of involvement begins and ends. In some situations, the referring agency may be requesting what is perceived as an 'expert' assessment to assist them in their planning process. External factors such as an impending case planning meeting or court hearing can be a powerful motivation for referral and may represent a reaching out from the child welfare system to what are sometimes seen as more powerful and influential professions in the mental health system. They may therefore only be seeking a psychiatric diagnosis and may not be interested in the mental health worker's perspective on other areas of the child's life.

A different scenario involves the mental health professional feeling that the child welfare professional is keen to 'pass the buck', passing on wider responsibility to the mental health professional for not only clinical matters, but also ongoing supervision and management of the child's life. Both parties may perceive the other as 'not doing enough', for example, believing that, if only the child was seen for therapy (the child welfare perspective) or placed appropriately and provided with more supports (the mental health perspective), the problem would go away.

Therefore not only is the entry pathway different for children from both these groups but the scrutiny they receive is very different. The scrutiny that Group 1 receives is both economically and resource based. The intake workers determine whether the nature of the presenting problem is such that it could be dealt with in another setting, for example, a community health centre, or whether the parents are in a financial position to seek treatment within the private sector. If neither of these options is possible, the referral will be accepted.

However, for children in Group 2, the scrutiny involves clarifying whether the problem is one that requires a mental health solution or one which is more to do with the need for permanency and support. This involves understanding the meaning of the symptom at that time for the child.

A further issue involves referrals by health and welfare professionals who largely work with children who have experienced disruptions – are these Group 2 children being compared only to other children with similar backgrounds, rather than to the 'normal' child as other children are? If this is so, there is a risk of them being doubly disadvantaged.

In an earlier phase of this research (see Article 2 in this series), the Group 2 children present as having more problems than the Group 1 children, particularly in the area of their social skills. Is this the reason why they were referred – because their impaired social skills brought them to someone's notice?

The data set out in Table II would seem to confirm this hypothesis, as our research shows that children in Group 2 are more likely to be referred for externalizing or 'under-controlled' problems than Group 1 children, a finding which accords with other research (Howe & Hinings, 1987; Verhulst et al, 1990).

The clinical experience and practice wisdom of professionals in child and adolescent mental health settings very strongly states that children who have experienced non-biological care do have more serious psychological, emotional and social problems, frequently co-existing with significant difficulties in education; speech and language; and sensori-motor abilities. The fact that our findings (Table II) give very little indication of these latter problems does not, *per se*, indicate that they are not issues for the Group 2 children. As discussed above, it is far more likely that it reflects the information available to mental health staff at the time of intake to the clinical process.

CONCLUSION

The research presented here was undertaken in an attempt to understand the differences between Groups 1 and 2 children in terms of who refers them to child and adolescent mental health services – and why. However, we have only just scratched the surface in answering these questions. Further research is needed in this area to increase our knowledge of the systemic issues involved in such referrals, in order to ensure that children receive treatment and support which is appropriate to their needs. □

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LETTER TO THE EDITOR

I would like to thank Anne Elliott (*Children Australia*, Vol.23, No.4) for sharing her critical ideas about the lack of incentives to focus on the child's needs in traditional western child protection systems. I believe she is opening the way for a very healthy debate and I hope that *Children Australia* is able to encourage further articles that challenge the concentration on parental blame and promote a safety building focus in child protection. There are many stories about parents being alienated, shamed and then excused from taking up their responsibilities. There are many stories about parents working in partnership with other family members, protective workers and others to ensure their children are safer and well nurtured. Research confirms that safety is built most constructively within an open and trusting relationship between parents and workers. Focusing on what the parent has done to or not done for the child is seldom an invitation for the parent to join the safety building team. Focusing on the child's needs taps into a basic concern all parents have for their children. They want their children to have a fair go. The parent can feel respected as a person whose contribution is valued and expected.

As I read Anne's article, I discovered I had at least two dominant thoughts that need further development running through my mind.

The first was on the way in which precious public resources are allocated. For example, I have been concerned for some time about the increasing number of young children coming into care because their parents are being pushed around by drugs. The emphasis on the system's need for the parent to overcome the power of the drug means children's needs are being put on hold. They are waiting, often in substitute care, for unacceptable lengths of time before realistic plans and practices based on their needs for security and reassurance are developed. It seems to me that framing the parent first as a person who can contribute to the child's security, and second as a victim of a dominating drug will better ensure that resource allocation will be more child centred.

The second was my belief that there is a strong link between case management that is child centred and family inclusive, and improved client centred collaboration between agencies. When the focus is on parental blame and deficit, specialised services compete on the basis of 'diagnostic wisdom'. when the focus is on building safety so that children's needs are met, family members and services have a common intention and can contribute in a complementary fashion.

I wondered what other readers thought.

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