Child psychiatric disorders among primary mental health service attenders

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SUMMARY
The aim of this study was to establish the range of psychiatric disorders and psychiatric comorbidity among children and adolescents attending a primary mental health service (PMHS). The main psychiatric diagnostic categories were: oppositional defiant disorders (ODDs) (75.3%), anxiety disorders (36.1%), mood disorders (35.1%), and attention deficit hyperactivity disorders (ADHDs) (28.9%). The study found high rates (61.8%) of psychiatric comorbidity. It concludes that training in the recognition of likely psychiatric comorbidity in this population is essential for professionals working in the interface between primary and specialist services.

Keywords: primary mental health services; child and adolescent mental health services; mental health problems; child psychiatric disorders.

Introduction
MENTAL health problems and disorders are commonly reported among children and adolescents attending primary care services, such as general practices or community paediatric clinics. Because of this, and following the recommendations of the National Health Service (NHS) Health Advisory Service, a number of child and adolescent mental health services have established posts for primary mental health workers (PMHWs). The role of the PMHW is undertaken by a senior professional from a mental health background, i.e. nursing, social work, psychology, occupational therapy, or medicine. Their objective is to span the interface between primary care, including paediatric clinics and specialist services. In addition to direct clinical work with children and families, PMHWs offer specialist consultations, training, supervision, and support, to primary care professionals.

As the primary mental health service is newly developed, little is known about the nature of psychiatric disorders among attending children and adolescents. The aim of this study was to establish the range of psychiatric disorders and psychiatric comorbidity among the population of children and adolescents attending this new service.

Method
Sample
The patients selected for the study were consecutive referrals to the Leicestershire primary mental health service for direct work over a one-year period. This service was developed in 1999 after a successful bid for child and adolescent mental health services (CAMHS) waiting-list funding. It consists of seven PMHWs, each serving a locality with a population of 50 000. Three of them had specialist social worker backgrounds, three had nursing backgrounds, and one of them had a specialist health visiting background. With the exception of the health visiting background, this is the usual breakdown nationally.

Primary mental health workers have been developing links within their target localities. These comprise a meeting with primary care professionals, such as general practitioners (GPs), health visitors, school nurses, educational psychologists, and special education needs co-ordinators (SENCOs), social workers, and the voluntary sector. It has been agreed that when it becomes apparent that a child’s difficulties are not responding to methods and interventions tried by the primary care worker, they can be referred to the primary mental health service and when it is established, through contact with the PMHW, that the child’s mental health needs cannot be supported through the consultation process only, they will be accepted for direct work by the PMHWs. Patients selected for this approach have usually proved to be resistant to interventions at a primary care level, but are not
considered appropriate for a more specialist intervention from CAMHS. Direct work is tailored to meet the needs of the child and family, i.e., parenting training, cognitive behavioural therapy, solution-focused brief therapy, and anger management. Primary mental health workers can advise both professionals and families on simple behavioural techniques for problems, such as temper tantrums, other oppositional behaviour, sleep problems, or bed wetting; while this is often the remit of the primary care professional, such problems can be commonly found to defy intervention. They can also offer intervention for families dealing with stress, which may include maternal depression and/or loss of confidence in the ability to parent, or advice on concerns regarding school.

As funding was not adequate to cover the whole health district, targeted localities were initially prioritised according to deprivation in inner city, semi-urban, and rural areas, as an indicator of higher child mental health needs. The primary mental health service is, however, currently expanding to the remaining localities, in consultation with primary care trusts.

**Instruments**

The Schedule for Affective Disorders and Schizophrenia for School-Age Children — (KSADS)\(^5\) is a semi-structured diagnostic interview designed to assess current psychopathology in children and adolescents, according to the DSM-IV classification system. The diagnostic categories are grouped into five major sections: affective disorders, emotional disorders, behavioural disorders, psychoses, and other disorders. The reliability and validity of the instrument is well established in clinical and community populations.\(^6\) The children and the parents were assessed using this interview technique, which took up to two hours to complete.

**Results**

Out of 117 children and families who fulfilled the research inclusion criteria over a 12-month period, 12 (10.2%) refused to participate, and 6 (6.8%) could not be contacted, with the remaining 97 children and parents taking part (a response rate of 82.9%). There were more boys (n = 60, 61.9%) than girls (n = 37, 38.1%) attending this service, and the mean age of the children was 10.1 years (range = 6 to 16). General practitioners were the main referrers to this new service (n = 81, 83.5%).

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n (%)</th>
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<tbody>
<tr>
<td>ODD/CD</td>
<td>22 (22.7)</td>
</tr>
<tr>
<td>ADHD and ODD</td>
<td>15 (15.5)</td>
</tr>
<tr>
<td>More than three diagnoses</td>
<td>13 (13.4)</td>
</tr>
<tr>
<td>Depressive disorder and ODD</td>
<td>10 (10.3)</td>
</tr>
<tr>
<td>Anxiety disorder and ODD/CD</td>
<td>9 (9.3)</td>
</tr>
<tr>
<td>Depression disorder and anxiety disorder</td>
<td>9 (9.3)</td>
</tr>
<tr>
<td>Depressive disorder</td>
<td>5 (5.1)</td>
</tr>
<tr>
<td>Anxiety disorder and ODD and ADHD</td>
<td>4 (4.1)</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>4 (4.1)</td>
</tr>
<tr>
<td>ADHD</td>
<td>3 (3.1)</td>
</tr>
<tr>
<td>No psychiatric disorder</td>
<td>3 (3.1)</td>
</tr>
<tr>
<td>Total</td>
<td>97 (100)</td>
</tr>
</tbody>
</table>

**Schedule of Affective Disorders and Schizophrenia for School-Age Children — (KSADS)**

Oppositional defiant disorder/conduct disorder (ODD/CD) was the most frequent diagnostic category, with about three-quarters (n = 73, 75.3%) of the children fulfilling diagnostic criteria. There were high rates of psychiatric comorbidity. Out of the 97 children, three (3.1%) did not have any psychiatric disorder and 34 (35.1%) had one diagnosis. The remaining children (n = 60; 61.8%) fulfilled diagnostic criteria for more than one diagnosis. The most prevalent psychiatric comorbidities were ODDs and anxiety disorders.

**Discussion**

The development of the primary mental health service has addressed the gap between primary and specialist services for children and adolescents with mental health disorders. However, this may not be the only way to deliver services for this population. A recent paper has proposed the creation of an intermediate level of specialist (a GP with a special interest), who would increase access at a location close to the patient while giving support to the wider primary health community.\(^7\) The primary mental health service aims to work with children with mild to moderate problems, particularly oppositional disorders, to enable specialist CAMHS staff to manage the more severe psychiatric disorders. In this respect, the findings confirmed that, on the whole, referred patients accepted for direct work by PMHWs fulfilled their core service criteria, i.e. they were suffering predominantly from ODDs, mild depressive disorders, and anxiety disorders. As expected, there were no children or adolescents with eating, bipolar mood, or schizophrenic disorders, who would have been referred directly to a specialist CAMHS. The nature of these less complex disorders could be identified by GPs, although their time-consuming management and concurrent educational or social needs would often require professionals operating on the interface between primary and specialist services.

The key finding, however, was the rate of comorbid psychiatric disorders. In particular, a large number of children described by parents as having ODDs also fulfilled diagnostic criteria for another psychiatric disorder. Such disorders were: attention deficit hyperactivity disorder (ADHD), mood disorder, and a range of anxiety disorders. More than a quarter of the children and adolescents suffered from mood...
disorders, particularly minor depression and separation anxiety disorder, without comorbidity with ODD. Unfortunately, the research instrument did not include developmental disorders, including autism.

The need for recognition of possible disorders and identification of the most appropriate service for each child and family, indicates the importance of ongoing training for PMHWs, particularly in relation to more complex child and adolescent mental health problems. As this study was not intended to evaluate the PMHW service, this should be the aim of future research.

References