

Patterns of Attendance of Child Psychiatry Out-patients with Special Reference to Asian Families

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Asian and non-Asian referrals to the department of child psychiatry at the London Hospital in 1987 were analysed. Asian referrals were under-represented with respect to the local population but, contrary to our expectations, there were no significant differences between the groups with regard to demographic data, the nature of the presenting problem, and attrition rates.

There is a general impression among those who work in areas with a large Asian population that Asian children are under-represented in child psychiatry clinics. Kallarackal & Herbert (1976) suggested that apparently lower rates of disturbance in Asian children might be due to parents not recognising certain types of behaviour as problems. A number of other possible explanations exist. Asian children may show lower rates of disturbance generally; Cochrane & Stopes-Rose (1977) in a survey of adult Asian immigrants suggested that Asians were better adjusted than their native counterparts on a number of social and psychological parameters. Alternatively, Asian children might show the same or higher rates of disorder, but a range of factors prevent their families from presenting to psychiatric services. Cultural norms may prevent help being sought outside the extended family, and communication problems due to lack of fluency in the host culture's language have been implicated in non-attendance at out-patient clinics (Deyo & Inui, 1980).

Newth (1986), in her review of emotional and behavioural disorders in the children of Asian immigrants, highlights the lack of research in this area and the need for further study. Problems with research concern the difficulty of finding suitable control groups in the UK, and the lack of good studies in Asia giving clear rates of child psychiatric disorder.

A major concern of those working in areas with a large Asian population is that the services provided are in some way failing to meet the needs of the local community. Clearly there is a need for hard epidemiological data about rates of disorder, but in the absence of these, an analysis of clinic attendance and 'administrative' outcome (non-attendance, dropout, agreed discharge, etc.) can provide some useful information about service provision (Pound & Cottrell, 1989).

The London Borough of Tower Hamlets has a large number of Asian immigrants, mostly from Bangladesh although it is difficult to obtain exact figures. The 1981 census (London Borough of Tower Hamlets, 1983) reported that 8% of people were of Asian origin. The Spitalfields Working Party (1984) produced a figure of 10–13% for the Bangladeshi population in 1984 and a predicted figure of 15% for 1987. These are percentages of the total population. It is our clinical impression that Tower Hamlets has a high birth rate, which may possibly be accounted for by the tendency of immigrant families to replicate patterns of family size prevalent in their country of origin. This suggests that the percentage of children from Bangladesh may be higher than the above figures. Statistics from the Inner London Education Authority (1985) show that, in 1985, 33% of school-age children in Tower Hamlets were from Bangladesh.

The present study reports on the pattern of referrals to the child psychiatry department at the London Hospital with particular reference to Asian children. The hypotheses to be examined are that Asian children will be more likely to fail to attend or drop out of treatment, and will show a different pattern of presenting problems.

Method

The study is a retrospective case-note analysis of referrals to the Department of Child Psychiatry at the London Hospital. The department operates an open referral system and accepts self-referrals as well as referrals from non-medical professionals in the area. Referrals are mostly from the western end of the London Borough of Tower Hamlets (children at the other end are seen at a community-based child psychiatric service), but there is no formal catchment area and referrals are received from further afield. The department contains the usual mixture of professionals working in a multidisciplinary team (child psychiatrists, psychologist, psychotherapists, and psychiatric social

workers). All of the staff are white caucasians and none speak Bengali. An interpretation service is available in the hospital.

The sample consisted of all 205 referrals to the department in 1987. Of these, 16 were excluded as no appointment had been offered: eight referrals were from various professional colleagues who had not sought parental permission for referral and this was subsequently denied; five were still awaiting a first appointment at the end of 1987 when data analysis was started; and three were specific requests for services which the department could not provide (e.g. day care). This left a sample of 189 patients.

Case notes were examined in a standardised way and the following data recorded: age and sex of index child, ethnic origin of child, marital status of parents, distance of family from hospital, referral source, presenting problem, and presence of interpreter at appointments. In addition, the 'administrative outcome' of the referral was recorded (i.e. non-attenders, early drop-outs (attended once only), late drop-outs (attended more than once but family unilaterally terminated treatment), agreed termination, and treatment still ongoing (Cottrell *et al*, 1988)). An attempt was made to contact those families who did not attend (by telephone and letter) to try to determine their reasons for non-attendance.

Data for the whole sample were analysed to determine what factors (if any) influenced attendance, and these were compared between the Asian and non-Asian groups. The χ^2 test with Yates' correction was used; Fisher's exact probability was used where sample size was small.

Results

The age and sex distribution of the sample was unremarkable (58% boys, 42% girls) (Table I). Three-quarters of the sample were resident in Tower Hamlets, 14% were from other London boroughs, and 11% from outside greater London. Over a third of the children (38%) came from single-parent households. The greatest number of referrals came from within the hospital (35%), most of these being from the paediatric department. General practice was the next highest source of referrals (22%), followed by social services (17%), education (15%), and self-referral (5%). The reasons for which the children were referred are listed in Table II.

Asian families accounted for 27 (14%) of the total sample. Of the 142 referrals of children resident in Tower Hamlets, 23 (16%) were Asian, and 18 (12%) of these were from Bangladesh.

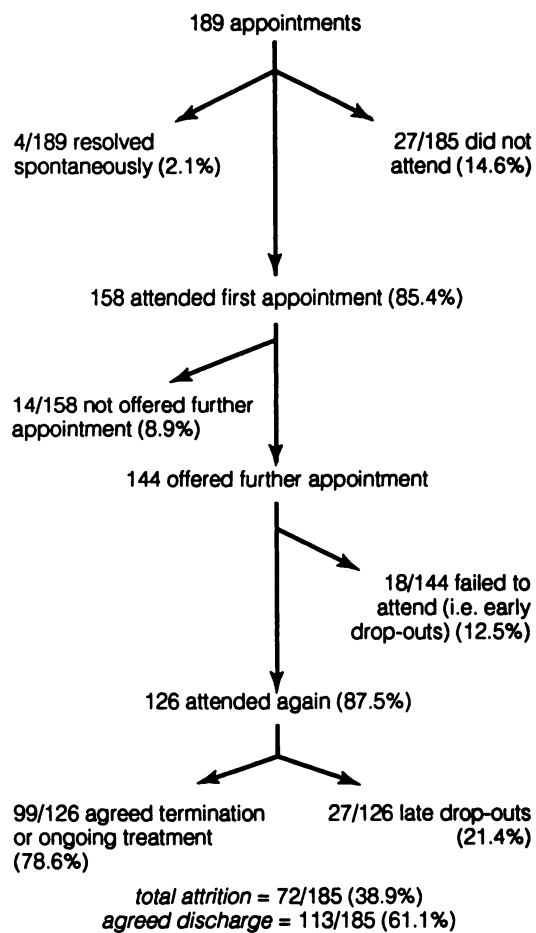


FIG. 1 Overall outcome of referrals for 1987.

TABLE I
Distribution of race, sex and age

Age (years)	Asian (n = 27)		Non-Asian (n = 162)		Total sample (n = 189)	%
	male	female	male	female		
0-5	2	2	39	17	60	32
6-10	6	3	30	14	53	28
11-14	4	4	20	14	42	22
15+	2	4	8	20	34	18
Totals	14	13	97	65	189	100

No statistically significant differences.

TABLE II
Frequency of presenting problems¹

Reasons for referral	Total sample		Asian		Non-Asian	
	n	%	n	%	n	%
Conduct disorder	83	44	11	41	72	38
Child abuse	31	16.4	5	18	26	16
Emotional disorder	35	18.5	3	11	32	18
Enuresis and/or encopresis	16	8.5	3	11	13	8
Overdose	5	2.6	2	7	3	2
Developmental delay	6	3.2	1	4	5	3
Psychosis	1	0.5	1	4	—	—
Marital and family problems	1	0.5	1	4	—	—
Requests for assessment and reports (psychometric, court, etc.)	11	5.8	—	—	11	15
Totals	189	100	27	100	162	100

1. Included in the total are those cases who spontaneously recovered.
No statistically significant differences.

The outcome of the sample is shown in Fig. 1. Of those who did not attend at all, 13 of the 27, three of whom were Asian, had not wanted a referral in the first place. The remaining 14 families did not reply to our inquiries.

Comparison of Asian and non-Asian referrals

There were no statistically significant differences between these two groups in terms of age, sex, area of residence, marital status of parents, referral source, or outcome. An interpreter was required for 11 (41%) of the Asian families referred, but these families did not differ significantly in outcome from either the Asian families who did not require an interpreter or the non-Asian families.

Although the overall pattern of presenting problems was similar in both groups, there were some non-significant differences. Generally the non-Asian children presented with a wider range of problems, and within the category of conduct disorder there were no Asian referrals for sleeping problems, truancy, or substance abuse. Within the category of emotional disorder Asian referrals were confined to depression and psychosomatic complaints, whereas within the non-Asian group there were a number of referrals for school refusal, eating disorders, anxiety states, and abnormal grief reactions.

When referrals were broken down by age, the following points emerged: the drop-out rate for pre-school Asian referrals was 50%; no pre-school Asian children were referred as a result of child sexual abuse, nor were there any pre-school Asian referrals for sleeping problems, enuresis, or encopresis. There was a steady increase with age, in both Asian and non-Asian groups, of the proportion of emotional problems referred (as opposed to conduct disorders).

Other factors influencing attendance

All social service referrals attended the first appointment. All referrals concerning developmental delay and 75% of

those Asian children referred by the education services ended with agreed termination of treatment. Numbers were too small to allow for valid statistical analysis.

Discussion

This is a retrospective study and therefore contains all the drawbacks of such studies; however, some valid conclusions are possible. Clearly, Asian children referred to the department are under-represented when compared with the local population. Only 12% of referrals were from Bangladeshi families in Tower Hamlets, when the Inner London Education Authority (1985) suggested that 33% of school-age children were from Bangladesh in 1985. This is likely to be an underestimate as the London Hospital receives most of its referrals from the west end of the borough, which is where most of the Bangladeshi families are concentrated.

An important contributing factor to the shortfall in expected Bangladeshi referrals may be the local population's perception of the causes of unwanted behaviour in children. According to discussions with local people and Bengali-speaking professionals, most parents believe unwanted behaviour in children to be due to 'badness' (which is dealt with by punishment), physical illness, or the activity of spirits. In the area of Bangladesh from which our local population comes, child psychiatric services are virtually non-existent and there is therefore no expectation that psychiatric help might be useful.

Another possibility is that the clinic does not meet the needs of the local population. The fact that those Asian children who are referred are reaching our department via the same sources as other referrals

and have a broadly similar outcome suggests that this is not the case, and refutes the hypothesis that Asian referrals would have a higher drop-out rate. Of course referrers may be referring only those Asian families they think will engage in treatment. The fact that Asian and non-Asian groups had similar drop-out rates and that 40% of the Asian referrals needed an interpreter (which in this study did not affect outcome) suggests that this is not the case.

With regard to presenting problems, there is a non-significant trend for Asian children to be referred with a narrower range of problems, particularly in the pre-school age group. Discussions with Asian parents at interview suggested that a wider range of pre-school behaviour is tolerated as 'normal', and that a lesser degree of autonomy is expected in younger children than in non-Asian families. Although the drop-out rate of 50% in pre-school Asian children may be due to a number of reasons, it is our impression that parents are less concerned about behaviour identified by referrers as problematic in this age group.

It is of interest to note that while other studies (Gould *et al*, 1985) have suggested that drop-out occurs most frequently with school referrals, this was not the case with local Asian children referred by the education service. This may reflect the very high value placed on education by local Asian parents.

Of particular concern with retrospective studies is the lack of information about families who do not attend at all. In this study attempts were made to contact such families and although only about half were reached, it is of interest that all of these families were against referral from the outset. Given the waste of specialist resources involved when families fail to attend, referrers should perhaps consider alternative options when faced with families who seem resistant to referral to child psychiatry. Joint consultations with family, referrer, and child psychiatrist in the referrer's setting might be one alternative.

In conclusion, it is clear that Asian children are under-represented in referrals to this clinic. It is suggested that this may in part be due to cultural differences concerning what is acceptable behaviour in children and concerning why some children's behaviour is thought to be problematic. Without proper epidemiological studies, it is impossible to tell how much child psychiatric disorder is being missed. It is encouraging that once a referral has been made, cultural factors do not seem to play a major part in affecting outcome.

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