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# A Child Psychiatry Consultation Service to Paediatricians

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**Introduction**

Much has been written on the general theme of psychiatric consultation services to medical colleagues, and a comprehensive review of the literature has been provided by Lipowski (1967). Most of the consultation services reported in the literature describe a preponderance of referrals from medical rather than surgical wards, but either do not comment on paediatric referrals or specifically exclude them from consideration. Nevertheless, there have been frequent calls for a close relationship between child psychiatry and paediatric practice (*e.g.* Winnicott 1963, Pinkerton 1973), and the importance of a developmental approach in both paediatrics and child psychiatry has been particularly stressed by such eminent child psychiatrists as Eisenberg (1967) and Solnit and Senn (1954).

Examples of active collaboration between child psychiatry services and paediatrics has been described by Tisza and Richardson (1956), Gardner (1958), Chess and Lyman (1969) and Levine *et al.* (1975). These provide valuable accounts of how integration may be successfully achieved, and how such a service has modified or developed the existing service.

Very little has been reported, however, about the range of disorders encountered in paediatric referrals to child psychiatry departments, or about other characteristics of the patients and their families, the subsequent outcome, and issues related to these points. Therefore it was to these themes that this present research was addressed. This paper provides an account of a child psychiatric consultation service to the paediatric out-patient departments and in-patient wards of the Tyneside group of hospitals. This service was provided by the sole child psychiatry service unit attached to the main teaching hospital. A description of this unit is available elsewhere (Connell 1961, Ackral *et al.* 1968).

**Method**

The pattern of referrals to this Unit was studied by examining case records. First we studied a consecutive sample of 218 patients referred over a 3½-month period. Some 47 per cent were non-urgent referrals from paediatricians and only 2 per cent were from other medical departments. 27 per cent were referrals from general practitioners, and 16 per cent were out-patients referred by various community agencies (see Table I). Secondly, four groups of patients were selected for more

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intensive study:
(1) a random selection of 37 children (19 boys, 18 girls) from the 108 out-patients referred by medical departments;
(2) a random selection of 32 (16 boys, 16 girls) from the 59 general-practitioner referrals;
(3) all 35 out-patients referred by community agencies.
(4) The ward consultation group consisted of only 17 cases (8 per cent). To increase the size of this group, therefore, we extended the period of our survey to cover one year, which yielded 50 cases (20 boys, 30 girls) for this ward consultation group. This group therefore comprises all the children referred by other hospital departments requesting urgent consultation on whichever ward the child was a patient.

The hospital case-notes of groups 1, 2 and 4 were examined to determine the sex and age distributions, the types of psychiatric disorder (employing both a clinical classification and the WHO tri-axial diagnostic groupings), and the prevalence of any associated physical or psychosocial disorder or handicap.

For the purpose of this study, the first axis of the original WHO tri-axial classification (see Rutter *et al.* 1969) was employed, as readers are likely to be more familiar with this than with the more recent multi-axial classification. The second method chosen to describe the disorders encountered was an *ad hoc* clinical descriptive method, specifically designed to fit the clinical material. Ten descriptive categories were agreed upon.
(1) *Neuropsychiatric and psychotic disorders,* which included the most serious disorders, often with a clear-cut physical basis.
(2) *Complex medical problems,* which included diabetic and other endocrinal disorders complicated by family problems and behavioural difficulties.
(3) *Somatic symptoms with a presumed psychological basis:* this covered the so-called 'hysterical conversion states', the most commonly accepted group of psychosomatic disorders (*i.e.* asthma, ulcerative colitis and certain skin disorders) and a wide range of aches and pains (notably abdominal).
(4) *Disorders of appetite,* covering both extremes—serious obesity problems and anorexia nervosa.
(5) *Serious neurotic and allied disorders,* which included the school phobic syndrome, depression and suicide attempts.
(6) *Behaviour disorders in adolescents,* such as rebellion or running away from home.
(7) *Enuresis and encopresis.*
(8) *Antisocial disorders:* these are also referred to as 'conduct disorders' (Rutter 1965) and include such symptoms as cruelty, bullying, destructiveness and delinquency.
(9) *Less serious neurotic disorders*—minor or transient neurotic disorders and disorders reactive to environmental stresses.
(10) *Retarded development:* those referred because of concern about intellectual retardation or speech delays associated with behavioural problems.

The outcome in each case was recorded, together with an assessment of the subsequent co-operation established with the child's parents. Finally, for the ward consultation group, an attempt was made to determine whether the child's hospital admission had been an acute or a planned one, and to determine the main reason for psychiatric referral.

To sum up, we selected 154 children for more intensive study (group 1=37, group 2=32, group 3=35, group 4=50). The 50 cases in group 4 constituted the entire complement of ward referrals for a one-year period. In addition, the hospital case-notes of 119 of the children (groups 1, 2 and 4) were examined for the purpose of classification

## Results

*Review of Consecutive Sample of 218 Children*

Fifty-five per cent of this sample had been referred by paediatricians (Table I). Almost one-quarter of such requests were for psychological assessment only, and almost one-fifth of the remainder were requests by paediatricians that the initial psychiatric consultation should take place on the ward in which the child was a patient. The majority of the non-paediatric referrals were also from medical sources, most often the requests of general practitioners. Non-medical referrals amounted to less than one-sixth of the total of new referrals over the period studied. As only four cases had also been referred to other clinics by the paediatricians, it would seem that our samples constituted almost the total number of paediatric referrals for psychiatric opinion during that period.

The sex ratio of the children referred by medically qualified professionals (*i.e.* hospital doctors and general practitioners) was approximately 1:1 (Table II). There was an excess of girls in the ward consultation group, which remained when cases of self-poisoning were excluded. The excess of boys reported in most clinical and epidemiological child psychiatry research was apparent only in the relatively small group of children referred by school or community agencies.

TABLE I

**Source of referral of 218 patients**

| *Source of referral* | *No.* | % |
|---|---|---|
| Hospital departments | | |
| Paediatric referrals: for psychological assessment | 26 | 12·0 |
| psychiatric out-patient assessment | 76 | 35·0 |
| psychiatric ward consultation | 17 | 8·0 |
| Other medical referrals, out-patients | 4 | 2·0 |
| General practitioner referrals | 60 | 27·0 |
| Referrals from community agencies, school medical/psychological services, probation and social services | 35 | 16·0 |
| | 218 | 100·0 |

TABLE II

**Sex ratio by referral source**

| *Source of referral* | *No.* | *Male: female ratio* |
|---|---|---|
| Urgent referral—ward consultation | 50 | 0·7:1 |
| Non-urgent hospital referral | 37 | 1:1 |
| General-practitioner referrals | 32 | 1:1 |
| Other referrals | 35 | 3·2:1 |

*Referral Rate of Paediatric In-patients*

During the period of study, approximately 5000 children were admitted to paediatric departments serving Tyneside, so the psychiatric consultation rate was approaching 10 per 1000 in-patients. This figure does not include referrals from out-patients, nor those who had previously been in-patients.

*Reasons for Psychiatric Referral in Ward Consultation Group*

Most of the children in the ward consultation group had been admitted to hospital from waiting lists for the observation, investigation or treatment of their symptoms. Only a minority (28 per cent) had been emergency admissions, and half of these had followed self-poisoning (Table III).

In 86 per cent of cases the basis of referral was positive evidence of psychological disturbance, and in only a few cases was referral prompted by the absence of a demonstrable physical explanation for the child's symptoms. In the majority of cases the request was for an opinion as to the nature and severity of

the evident psychological disturbance, and whether specific treatment was needed. In one-fifth of the cases advice was sought about the management of the psychological components of complex medical problems.

*Management Recommendations and Parental Co-operation*

For the majority of children referred in each of the three groups a psychiatric treatment recommendation was made after the initial consultation (Table IV). However, it was clear from the case-notes that parental co-operation, in terms of attending most or all their subsequent appointments, was poor. Quite often families actively withdrew from treatment, and most frequently these were from the ward consultation group.

TABLE III

**Reason for referral of children in ward consultation group**

| *Reason* | *Emergency admissions* (N = 14) | *Planned admissions* (N = 36) |
|---|---|---|
| | % | % |
| Psychological disturbance evident: | | |
| General psychiatric opinion of evident psychological disturbance | 12·0 | 40·0 |
| Advice on psychological management of complex medical problem | — | 20·0 |
| Opinion following suicide attempt | 14·0 | — |
| No evident organic basis for symptoms | 2·0 | 12·0 |

*Psychiatric Disorders Present in the Three Groups*

Conduct disorders, minor neurotic disorders, adolescent crises, and cases in which there was concern about possible retardation made up the greater proportion of general-practitioner referrals. In contrast, these were markedly under-represented in the paediatric referrals (Table V). On the other hand, somatic manifestations of psychological disorders (*e.g.* conversion symptoms, abdominal pains, headaches, dizziness) were present in the majority of children in the two hospital groups but were relatively infrequent in the general-practitioner referrals.

Understandably, children who had made suicide attempts were represented mainly in the ward consultation group; otherwise the distribution of psychiatric disorders in the two hospital groups were similar.

The second method of classification, employing the WHO tri-axial method, is shown in Table VI. This method demonstrated the considerable proportion of children (38 per cent) referred by general practitioners whose psychological disturbance was felt to be reactive to environmental circumstances. These included many minor or transient symptoms in young children or adolescents, secondary to inappropriate handling or disturbed parent-child relationships (*e.g.* sleeping or feeding difficulties in infants, and threaten-

TABLE IV

**Outcome after psychiatric assessment**

| *Source of referral* | *Assessment and opinion only* | *Treatment offered* | *Attended well for treatment* |
|---|---|---|---|
| | % | % | % |
| Ward consultation (N = 50) | 28·0 | 72·0 | 53·0 |
| Non-urgent hospital referrals (N = 37) | 22·0 | 78·0 | 65·0 |
| General-practitioner referrals (N = 32) | 21·0 | 79·0 | 64·0 |

ing behaviour or running away in adolescents).

*Associated Handicaps*

The most common associated physical handicap was asthma, accounting for a third of the children with a physical disorder. The two other main groups of disorders were neurological and diabetes. As mentioned earlier, physical illness was uncommon among children referred by general practitioners. Adverse social experience (*i.e.* social, material or experiential deprivation, poor parental supervision and

TABLE V

**Clinical descriptive classification**

| *Classification* | *Ward consultation* (N = 50) | *Non-urgent hospital referrals* (N = 37) | *General-practitioner referrals* (N = 32) |
|---|---|---|---|
| | % | % | % |
| Neuropsychiatric and psychotic disorders: | 8·0 | 11·0 | — |
| Epilepsy and other sequelae of brain damage | 6·0 | 2·0 | — |
| Psychoses | 4·0 | 2·0 | — |
| Complex medical problems | | | |
| Somatic manifestations of psychological disturbance: | 10·0 | 5·0 | — |
| Hysterical conversion symptoms | 16·0 | 9·0 | 3·0 |
| Psychosomatic disorders | 8·0 | 13·0 | — |
| Vague aches/pains | 4·0 | 2·0 | — |
| Disorders of appetite | | | |
| Serious neurotic and allied disorders: | 6·0 | 8·0 | 3·0 |
| Depression | 6·0 | 18·0 | 16·0 |
| School refusal | 14·0 | 2·0 | 3·0 |
| Suicide attempts | — | 2·0 | 13·0 |
| Adolescent rebellion and other disorders | 6·0 | 2·0 | — |
| Enuresis and encopresis | 8·0 | 16·0 | 25·0 |
| Conduct disorders | 4·0 | 8·0 | 28·0 |
| Minor/transient neurotic and reactive disorders | — | — | 9·0 |
| Retarded development | | | |

TABLE VI

**First axis of tri-axial classification**

| *Clinical psychiatric syndrome* | *Ward consultation* (N = 50) | *Non-urgent hospital referrals* (N = 37) | *General-practitioner referrals* (N = 32) |
|---|---|---|---|
| | % | % | % |
| 0. Normal variation | 2·0 | 10·0 | 3·0 |
| 1. Adaptation reaction | 28·0 | 16·0 | 38·0 |
| 2. Specific developmental disorder | 8·0 | 5·0 | 9·0 |
| 3. Conduct disorders | 4·0 | 14·0 | 28·0 |
| 4. Neurotic disorders | 28·0 | 43·0 | 16·0 |
| 5. Psychoses | 4·0 | 3·0 | — |
| 5.1 Infantile | 2·0 | — | — |
| 5.3 Schizophrenia | 4·0 | 3·0 | 3·0 |
| 6. Personality disorder | 16·0 | 3·0 | — |
| 7. 'Psychosomatic' disorder | | | |
| 8. Other clinical syndromes | 2·0 | — | — |
| 8.2 Dementia | 2·0 | — | — |
| 8.4 Anorexia nervosa | — | 3·0 | 3·0 |
| 9. Manifestation of subnormality only | | | |

care) and disorders of intra-familial relationships were common in all groups, the latter being particularly frequent in the ward consultation group (Table VII).

## Discussion

The development of a child psychiatric department in Newcastle upon Tyne, and its links with paediatrics, has been actively encouraged by the university paediatrics department, which since the days of Sir James Spence has had a special interest in social paediatrics (Spence *et al.* 1954). The high proportion of the sample of children registered at the Nuffield Child Psychiatry Unit who were referred by paediatricians suggests that the working relationship between the two departments is an active and close one.

For such a service to be successful, good working relationships are crucial. In describing the service aspect of psychiatric consultation, Lipowski (1967) particularly emphasised the need for the psychiatrist to be of practical assistance, communicating his findings and recommendations in a clear, intelligible way, relevant to the presenting problem and the reasons for referral, and without employing psychiatric jargon. He stressed the sensitivity and tact that is required for this work. How much, and in what ways, the child psychiatry service is utilised by paediatricians is likely to be a reflection of such factors.

In Newcastle the paediatric ward consultation service was the method employed in a fifth of the paediatric requests for psychiatric consultation; nevertheless, this represented only a tiny minority of the children who were on paediatric wards. The referral rate resembles that reported for adult hospital patients, and the previously described rates for paediatric patients of between five and 15 per 1000 new patients (Schowalter and Solnit 1966, Vesterdal 1966, Chess and Lyman 1969, Levine *et al.* 1975). It differs little, too, from a recent estimate of an over-all psychiatric consultation rate of 12·6 per 1000 children at risk over the age of five in Newcastle (Morton and Kolvin 1975). As it is well recognised that the prevalence of psychiatric disorder in the school population is much greater than this, and greater still in those with a physical disorder (Rutter *et al.* 1970), those referred must represent only a small proportion of the pool of psychiatric morbidity in paediatric wards. One could therefore infer either that much psychiatric disturbance is dealt with by the paediatricians themselves, or that much or some of it remains unrecognised.

With the obvious exception of suicide attempts, it was not always easy to determine which factors were most important in determining psychiatric referral. Studies of adult psychiatric referral from general medical and surgical wards (Abrahamson 1971, Pritchard 1972, Maguire *et al.* 1974) suggest that among a number of important factors related to

TABLE VII

**Associated handicaps**

| *Source of referral* | *Disorders of intra-familial relationships* | *Physical illness in the child* | *Adverse social experience* |
|---|---|---|---|
| | % | % | % |
| Ward consultations (N = 50) | 62·0 | 36·0 | 26·0 |
| Non-urgent hospital referrals (N = 37) | 38·0 | 43·0 | 16·0 |
| General-practitioner referrals (N = 32) | 57·0 | 6·0 | 28·0 |

referral is the presence of behaviour which created problems in medical and nursing management. While this was also a significant factor in some of the paediatric referrals in the present study, an evident additional factor in many more was uncertainty about the relative importance or contribution of organic and obvious psychological factors to the disorder under investigation or treatment. A frequent reason for referral of adult patients has been the failure to find a physical explanation for the disorder under investigation (Fleminger and Mallett 1962, Kenyon and Rutter 1963), but in our study this was an unusual reason for referral. However, local factors must also influence the decision to refer, and in Newcastle our impression was that these local factors (notably the long-standing interest in social paediatrics) were of particular importance. Nevertheless, we believe that the range of disorders encountered is likely to be found wherever good paediatric-psychiatric collaboration exists.

With the exception of the very young, children of all age-groups were referred. The almost equal sex distribution found in these groups referred by hospital staff and by general practitioners reflected the sex distribution within their own patient population. Nevertheless, equal sex ratios are rather unusual in child psychiatric clinical practice and research; for instance, twice as many boys as girls were referred to a similar service in the paediatric outpatient department of the Hospital for Sick Children in Toronto (Levine *et al.* 1975). One possible explanation for the difference in the sex ratio of our groups compared with that usually reported in the literature is the relative under-representation of children referred by community agencies. This suggestion is supported by the findings in Table I, in which referrals from such sources manifested the usual sex ratio. The explanation cannot wholly lie in the differing types of psychiatric disorders referred, as the findings of the present study indicate marked differences in psychiatric disorders and associated physical handicap, yet similar sex ratios, between general-practitioner and hospital referrals.

Some form of psychiatric treatment recommendation was made for the majority of children referred in each of the three groups described, yet subsequent parental co-operation was poor in a third of the cases. Parental co-operation was unrelated to the presence or absence of a physical handicap, and also proved most difficult to obtain in those cases where consultation initially took place on the hospital ward. Few others have commented on this aspect of consultation, but the experience of those who have suggest that our experience is perhaps better than most. For instance, Vesterdal (1966) reported that only 36 per cent of paediatric referrals to psychiatric clinics completed their treatment; a quarter never attended at all. While various explanations have been offered (*e.g.* lengthy waiting lists detering attendance), parental lack of motivation and a preference for an organic explanation for their child's illness must play a part. Hence, careful preparation of parents by paediatricians and their junior staff would appear to be crucial in any attempt to improve co-operation.

Important differences were noted in the kinds of psychiatric disorder encountered among the two hospital and the general-practitioner referrals. The infrequency of physical symptomatology in those referred by the latter lends support to Haldane's suggestion (1972) that disturbed children with physical symptoms are by preference referred by general practitioners to paediatricians. In contrast, somatic manifestations of psychological disturbance were present in the majority of hospital referrals.

Excluding the inevitable excess of

suicide attempts among children in the ward consultation group, the distribution of psychiatric disorders in the two hospital groups was remarkably similar. About one-third of the ward consultation referrals were requests for urgent consultations for acute conditions such as school phobia, depression, hysterical conversion symptoms and suicide attempts. The remainder reflect the additional important aspect of the ward consultation service, namely that it provides a particularly convenient, rapid, and flexible service to paediatricians, allowing too a closer contact and dialogue with paediatric colleagues.

It is also evident that active consultation and collaboration between child psychiatric and paediatric disciplines is important, not only to do justice to the needs of the patients, who may frequently have severe psychosocial handicaps, but also to meet the training needs of the junior medical staff of both specialities. Further, it has been suggested that the introduction of a child psychiatry team to a paediatric ward or clinic is likely to lead to an increasing appreciation on behalf of both paediatric and nursing staff of the emotional needs of children and the interplay of social and psychological factors in even purely physical illnesses.

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SUMMARY

A review of referrals to the University department of child psychiatry in Newcastle upon Tyne demonstrated active consultation and collaboration between the department and paediatric departments. Important differences in sex, distribution of psychiatric disorders and presence of associated physical and social handicap were found between patients referred from different sources. The presence of some psychological disturbance in those children referred from hospital wards was evident to most paediatricians, and constituted the most frequent reason for referral. Recommendation for psychiatric treament was made for the majority of patients, but subsequent parental co-operation was often poor.

In the authors' view the greatest value of this research is that it highlights atrange of disorders of common concern to paediatricians and children's psychiatrists, using not only the terminology traditional in child psychiatry but also employing a descriptive terminology. They believe it is essential that trainees of both disciplines should have adequate experience in this wide range of disorders.

RÉSUMÉ

*Une consultation de psychiatrie infantile au service des pédiatres*

Un relevé des motifs de consultation, dans un service universitaire de psychiatrie infantile à Newcastle upon Tyne, a démontré une confrontation active et une collaboration entre ce service et les services de pédiatrie. Des différences importantes dans le sexe, la répartition des troubles psychiatriques, la présence de handicaps physiques et sociaux associés ont été notées entre les groupes de malades adressés par des sources différentes. La présence de perturbations psychologiques chez les enfants pris en charge hospitalière était évidente pour la plupart des pédiatres et constituait la raison la plus fréquente de consultations. Des

conseils pour le traitement psychiatrique ont été donnés pour la majorité des malades mais la coopération parentale ultérieure fut souvent pauvre.

Selon la vue des auteurs, le plus grand intérêt de cette recherche est de souligner un groupe de troubles préoccupant aussi bien les pédiatres que les psychiatres infantiles, utilisant non seulement la terminologie traditionnelle de la psychiatrie infantile, mais utilisant également une terminologie descriptive. Ils pensent qu'il est essentiel que la formation aux deux disciplines comporte une expérience adéquate dans le large domaine de ces troubles.

ZUSAMMENFASSUNG

*Kinderpsychiatrischer Beratungsdienst für Pädiater*

Eine Übersicht der Überweisungen zu der Abteilung für Kinderpsychiatrie der Universität Newcastle am Tyne zeigte eine aktive Konsultation und Zusammenarbeit zwischen dieser Abteilung und pädiatrischen Abteilungen. Es fanden sich bedeutende Unterschiede hinsichtlich des Geschlechtes, verschiedener psychiatrischer Erkrankungen und begleitender physischer und sozialer Probleme bei den Patienten, die von verschiedenen Stellen überwiesen wurden. Das Vorliegen bestimmter psychologischer Probleme bei den Kindern, die aus Kliniken überwiesen wurden, war von den meisten Pädiatern bereits erkannt worden und stellte den häufigsten Grund der Überweisungen dar. Bei den meisten Patienten war eine psychiatrische Behandlung empfohlen worden, jedoch war die Kooperation der Eltern häufig schlecht.

Nach Meinung der Autoren ist die Hauptbedeutung dieser Untersuchung die, eine Reihe von Erkrankungen von allgemeinen Interesse für Pädiater und Kinderpsychiater herauszustellen, indem nicht nur die herkömmliche Terminologie der Kinderpsychiatrie, sondern auch eine beschreibende Terminologie angewandt wird. Sie halten es für sehr wichtig, dass Assistenten beider Fachrichtungen Gelegenheit bekommen, auf diesem Sektor der Erkrankungen ausreichend Erfahrungen zu sammeln.

RESUMEN

*Un servicio de consultación psiquiátrica infantil para pediátras*

La revisión de los datos del Departamento de Psiquiatría infantil de la Universidad de Newcastle upon Tyne demostró la consultación activa y la colaboración entre el departamento de psiquiatría y el de pediatría. Se hallaron importantes diferencias en el sexo, distribución de la alteraciones psiquiátricas y la presencia de minusvalías asociadas físicas y sociales, entre los pacientes procedentes de origenes diferentes. La presencia de algunas alteraciones psicológicas en aquellos niños que habían sido enviados desde salas de hospitales fueron evidentes a la mayoría de los pediátras, y constituyeron la razón más frecuente para ser enviadas al servicio de psiquiatría. La recomendación para un tratamiento psiquiátrico fue hecha en la mayoría de los pacientes pero la cooperación paterna posterior a menudo fue pobre.

Desde el punto de vista de los autores, el valor más grande de esta investigación consiste en poner de relieve el margen de alteraciones que constituyen una preocupación corriente para los pediátras y los psiquiátras infantiles, utilizando no solo la terminología tradicional en la psiquiatría infantil sino también utilizando una terminología descriptiva. Los autores creen que es esencial que el aprendizaje en ambas disciplinas debería incluir una adecuada experiencia de este amplio campo de alteraciones.

## REFERENCES


Abrahamson, D. (1971) 'Psychiatry in a postgraduate teaching hospital.' *Postgraduate Medical Journal*, **47**, 583–588.

Ackral, N., Kolvin, I., Scott, D. Mc. I. (1968) 'A post-registration course in child psychiatry for nurses.' *Nursing Times Occasional Paper*, (5th April).

Chess, S., Lyman, M. S. (1969) 'A psychiatric unit in a general hospital pediatric clinic.' *American Journal of Orthopsychiatry*, **39**, 77–85.

Connell, P. H. (1961) 'The day-hospital approach in child psychiatry.' *Journal of Mental Science*, **107**, 969–977.

Eisenberg, L. (1967) 'The relationship between psychiatry and pediatrics—a disputatious view.' *Pediatrics*, **39**, 645–647.

Fleminger, J. O., Mallett, B. L. (1962) 'Psychiatric referrals from medical and surgical wards.' *Journal of Mental Science*, **108**, 183–190.

Gardner, C. E. (1958) 'The establishment of child psychiatry programs in a children's hospital.' *American Journal of Orthopsychiatry*, **28**, 523–533.

Haldane, J. D. (1972) 'How to use child psychiatry.' *British Medical Journal*, **3**, 520–522.

Kenyon, F. E., Rutter, M. L. (1963) 'The psychiatrist and the general hospital.' *Comprehensive Psychiatry*, **4**, 80–85.

Levine, S. V., Froese, A. P., Stewart, D. A. (1975) 'Child psychiatry and pediatrics: an integrated approach.' *Canadian Psychiatric Association Journal*, **20**, 47–53.

Lipowski, Z. J. (1967) 'Review of consultation psychiatry and psychosomatic medicine. Parts I and II.' *Psychosomatic Medicine*, **29**, 153–171, 201–224.

Maguire, G. P., Julier, D. L., Hawton, K. N., Bancroft, J. H. J. (1974) 'Psychiatric morbidity and referral on two general medical wards.' *British Medical Journal*, **1**, 268–270.

Morton, S. P., Kolvin, I. (1975) 'Services for the adolescent in the United Kingdom.' *In* Wallace, H. M. (Ed.) *Health Care of Mothers and Children in National Health Services: Implications for the United States*. Cambridge, Mass.: Ballinger. pp. 135–153.

Pinkerton, P. (1973) 'Paediatrics and child psychiatry—the case for collaboration.' *Archives of Disease in Childhood*, **48**, 970–974.

Pritchard, M. J. (1972) 'Who sees a psychiatrist? A study of factors related to psychiatric referral in the general hospital.' *Postgraduate Medical Journal*, **48**, 645–652.

Rutter, M., Lebovici, L., Eisenberg, L., Sneznevskij, A. V., Sadound, R., Brooke, E., Lin, T. Y. (1969) 'A tri-axial classification of mental disorders in childhood.' *Journal of Child Psychology and Psychiatry*, **10**, 41–61.

— Tizard, J., Whitmore, K. (1970) *Education, Health and Behaviour*. London: Longman.

Schowalter, J. E., Solnit, A. J. (1966) 'Child psychiatry consultation in a general hospital emergency room.' *Journal of the American Academy of Child Psychiatry*, **5**, 534–551.

Solnit, A. J., Senn, M. J. E. (1954) 'Teaching comprehensive pediatrics in an outpatient clinic.' *Pediatrics*, **14**, 547–556.

Spence, J. C., Walton, W. S., Miller, F. J. W., Court, S. D. M. (1954) *A Thousand Families in Newcastle-upon-Tyne*. London: O.U.P.

Tisza, V. B., Richardson, M. (1956) 'The integration of a mental health program and a child psychiatry unit in a pediatric hospital.' *Pediatrics*, **17**, 104–110.

Vesterdal, J. (1966) 'Referral of children to child psychologic and psychiatric treatment.' *Acta Paediatrica Scandinavica*, **55**, 244–245.

Winnicott, D. W. (1963) 'Symposium: Training for child psychiatry.' *Journal of Child Psychology and Psychiatry*, **4**, 85–91.