

# Paediatric Liaison Work by Child and Adolescent Mental Health Services

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**Background:** Although psychiatric morbidity is common amongst paediatric patients, little is known about the availability of CAMH paediatric liaison services. **Method:** We surveyed all Trusts with specialist CAMH services and paediatric units in Greater London, enquiring about the nature of liaison that CAMHS provide. **Results:** We found that although liaison paediatric work was common, dedicated paediatric liaison services were provided by only a minority of specialist multidisciplinary CAMHS. Their work involved most aspects of child psychopathology, and included emergencies and children with joint physical and psychiatric problems. About 2/3 of paediatricians were satisfied with CAMHS liaison services, but virtually all desired to see them developed further. There were few indications of co-ordination between specialist multidisciplinary CAMHS and other paediatric psychosocial support services.

**Keywords:** Paediatric; liaison; survey; CAMHS

## Introduction

Links between physical and mental health problems in children have long been recognised, as has the need for close integration of paediatric and child psychiatric practice. The desirability of liaison between psychiatric or child mental health and paediatric services has been endorsed by the development of dedicated services. Yet unlike work in adult liaison psychiatry, which in some countries has seen a rapid expansion in recent years (Swift & Guthrie, 2003), very little is known about the extent and nature of paediatric liaison work of this kind.

There is research evidence that associated psychopathology, mainly emotional disorders, are common and present in over a quarter of children attending general paediatric clinics (Fitzgerald, 1985; Garralda & Bailey, 1989; Costello & Shugart, 1992; Knapp & Harris, 1998; Glazebrook et al., 2003). Psychiatric disorders are increased in children with chronic and acute paediatric disorders (Gledhill, Rangel, & Garralda, 2000; Judge et al., 2002). There is recognition of a need to develop psychiatric or CAMH liaison services to attend to psychopathology as it presents in paediatric settings and for cases where there is a close relationship between physical and psychiatric symptoms. The Children's National Service Framework in the UK specifically stresses the importance of robust liaison arrangements between CAMHS and paediatric departments (Department of Health, 2004). Differing views and referral ambiguities can otherwise hamper the work (Oke & Mayer, 1991). Previous reports have described the work of these liaison services (Wrate & Kolvin, 1978; Bingley et al., 1980; Black, McFayden, & Broster, 1990; Black et al., 1999; Shugart, 1991; Vandvik, 1994). However, provision of this kind is

perceived as being generally scarce and insufficient (Kurtz, Thornes, & Wolkind, 1994; Audit Commission, 1999; Garralda, 2001; Bradley et al., 2003).

The survey presented here aimed to explore the nature and extent of paediatric liaison services provided in the London area, as perceived by both CAMHS and paediatric service providers. Although the survey is primarily about liaison provided by specialist multidisciplinary CAMHS, we also report on other psychosocial support services to paediatrics.

## Method

During 2001, contact was made with all Trusts listed with the Department of Health in the Greater London area providing specialist multidisciplinary CAMHS and acute paediatric services. Heads of services were contacted by telephone and lead clinicians identified who had sufficient information about service configuration to accurately respond to the questionnaire. Structured questionnaires were then sent to all 37 specialist CAMHS and 30 paediatric services identified. Both postal reminders and telephone contact followed up non-responders.

*The questionnaire for specialist CAMHS* was piloted with three sites known to be actively involved in liaison service provision, to ensure that the questions were unambiguous and could be completed accurately. It defined paediatric liaison as joint working across professional boundaries, when care is delivered by more than one specialty or profession. Consultation was defined as what happens when a specialist, either working individually or as part of a team, gives an opinion on a client or patient to another professional seeking advice - often without seeing the patient.

The questionnaire consisted of seven sections. First information was obtained about the CAMHS teams including geographical base, local paediatric hospital and existence of a paediatric liaison team. The second section enquired about the nature and extent of any 'direct' clinical work with paediatric patients, including emergency and non-emergency work, clinical settings and types of problems seen. In the third section similar information was sought with regards to 'indirect' clinical contact or consultation. The fourth section enquired about 'non-clinical' activity within paediatrics, including teaching, staff support, audit, and research. The fifth addressed demographic information, service planning, funding, and awareness of provision from any other mental health services to paediatrics. The sixth enquired about satisfaction with services provided to paediatrics. The last section sought to document staffing levels, in particular allocation to paediatric liaison activity. The provision of any particular service called for 'yes/no' answers, but estimates were accepted for questions on frequencies of referrals or activities.

The *questionnaire for paediatricians* enquired about provision of child mental health support, whether this was on a regular or ad hoc basis and whether this was specifically provided by specialist CAMHS or by another psychosocial support service (i.e. counsellor, psychologist, psychotherapist, play therapist, paediatric social services or other). Responders were given a list of 17 child mental health/problems and asked where they would usually refer such children, if at all, and to whom (whether to specialist CAMHS or to other psychosocial support services). The questionnaire explored views about the quality and extent of the child mental health input, information about its funding and about priorities for future service development. Details about the size of paediatric units were also obtained. Paediatric lead clinicians not responding to the postal questionnaire were contacted by phone and questionnaires were then completed by the first author through telephone interviews. The questions were always asked in the same order and any points clarified as appropriate.

Frequency analyses are reported here. Because of missing data to some questions total numbers in the results section may vary.

**Results**

*CAMHS survey*

*Characteristics of specialist multidisciplinary CAMHS services.* Of the 37 specialist multidisciplinary CAMHS approached, 27/37 (73%) returned questionnaires. Of these, 15 had a community and 16 had a hospital base (4 having both mixed community and hospital bases); 15 were linked to a teaching paediatric hospital, 9 to a district general hospital, and 2 to both. One service was not working with a local acute hospital but it co-ordinated its work with another local CAMHS who did. Twenty-one out of 27 responders were the only CAMHS providing a service to their local paediatric hospital, 4 offered co-ordinated and 2 uncoordinated supports with other CAMHS. The population served by specialist multidisciplinary CAMHS was predominantly urban (inner city 12/24 (50%), suburban 6/24 (25%), mixed 6/24 (25%). The median total catchment population was 205,000 (quartiles 200,000; 263,750), the yearly

referral rate 675 (300; 1100), the yearly referral rates per whole time equivalent (wte) staff was 53.6 (38; 65.4) and the waiting list 8 weeks (4; 13). Median staffing levels were 3 psychiatrists (including trainees) (quartiles 1.5; 5.7), 1.75 child psychotherapists (0.9; 3.1), 1.5 psychologists (0.6; 2.7), 1 nurse specialist (0; 2.5), 1 social worker (0; 4), 0.5 family therapists (0; 1.6). Fewer services reported occupational or creative therapists. The median number of professional staffing per 100,000 population was 6.5 (4.9; 8.5).

*Paediatric liaison service*

A paediatric liaison multi-disciplinary team (MDT) service was offered by 10/27 (37%) though only four (15%) offered this exclusively. In the other six services paediatric liaison was part of a broader range of CAMHS hospital and community work. Nevertheless, paediatric related work was carried out by most, whether they defined themselves as offering a designated paediatric liaison MDT or not.

Table 1 shows the type of services provided to paediatrics and the volume of work reported in each area. Routine outpatient work was offered by all and consultation and emergency referrals by virtually all, with an estimated median of one referral per week. More central liaison activities such as psychosocial ward attendance, joint outpatient clinics and joint ward rounds were offered less often. The most common links were with general paediatrics (in 21/27 or 78%) and accident and emergency units (16/27 or 59%). Of the specialist paediatric units, liaison was most usually provided to paediatric intensive care units or PICUs (10/27 or 37%), haematology (7/27 or 26%) oncology (7/27 or 26%), neurology (6/27 or 22%) and surgery (4/27 or 15%).

A consultation out-of-hours service was provided by 21/27 (77%). Mostly (12/27 or 44%) this took the form of combined consultation and assessment. There was flexibility in the geographical area covered. Non-catchment area referrals were accepted by the majority for emergencies and liaison over inpatients, though only half for routine out-patients.

Table 2 describes the types of clinical problems seen most commonly (expressed as the number of respondents mentioning a named problem as one of the top three referred to them). For emergency work, deliberate self-harm and psychoses were virtually always included. Disturbed behaviour and depression were mentioned by a third to a half. Clinical problems for inpatients were quite different, adjustment disorders to illness being the most common, followed by somatoform disorders. Other problems noted were disturbed behaviour, stress/adjustment disorders, anxiety, mood and

**Table 1.** CAMHS survey: Services provided to paediatrics (n = 27)

		Number of cases per month (median/quartiles)
Routine outpatients	27 (100%)	5 (2, 10)
Consultation	25 (93%)	4 (2, 12)
Emergencies	24 (89%)	5 (2, 9)
Routine inpatients	21 (78%)	3 (1.5, 7)
Psychosocial rounds	18 (67%)	11 (5.2, 27)
Joint out-patients	14 (52%)	4 (1, 11)
Joint rounds	5 (19%)	8 (2, 44)

**Table 2.** CAMHS survey: percentage of services rating individual problems amongst the three most common seen under different paediatric liaison activities ( $n = 27$ )

Emergencies (%)	Inpatients (%)	Outpatients (%)
DSH (91)	Adjustment to illness (70)	Somatoform D (78)
Psychoses (65)	Somatoform D (43)	Adjustment to illness (43)
Disturbed behaviour (43)	Disturbed behaviour (35)	Elimination (39)
Depression (30)	Stress-Adj D (26)	Depression (30)
Others (<7)	Anxiety D (22)	ADHD (22)
	Depression (22)	Eating D
	Elimination (13)	Autism
	Others (<7)	Disturbed behaviour
		Depression (17)
		Anxiety, CD, DSH (13)
		Other (<7)

Note: DSH = deliberate self-harm; D = disorder; Adj D = adjustment disorder; ADHD = Attention deficit hyperactivity disorder; CD = conduct disorder.

elimination disorders. Paediatricians referred comparable problems to CAMHS outpatients, but there was a broader range of problems mentioned, including ADHD, autism, and eating disorders.

The range of non-clinical paediatric liaison activities is outlined in Table 3. Most CAMHS offered formal teaching to doctors, medical students and nurses. However, only a minority were offering sessions at least monthly, most being either every two or three months, or on an irregular basis (irregular teaching was reported by 5/19 to medical students, 6/21 to doctors and 15/22 to nurses). Two-thirds offered staff support to general paediatrics (most at least on a monthly basis) and a third to PICU. Few offered staff support to other paediatric units.

Psychiatrists were most likely to be involved in liaison work, but in half of services this was on an ad hoc basis: consultant psychiatrists with more regular commitments tended to offer one or two sessions (or half days) a week (7/24 or 29%). Psychology and nursing input, when present, was least likely to be on an ad hoc basis

**Table 3.** CAMHS survey: non-clinical activities and CAMHS staff involved in paediatric liaison ( $n = 27$ ) (+)

		At least monthly
<b>Teaching (formal)</b>		
Medical students	76% (19/25)	42% (8/19)
Doctors	84% (21/25)	33% (7/21)
Nurses	81% (22/27)	23% (5/22)
<b>Support</b>		
General paediatrics	69% (18/26)	78% (14/18)
PICU	38% (10/26)	70% (7/10)
Other 1	15% (4/26)	75% (3/4)
Other 2	12% (3/26)	100% (3/3)
<b>Profession involved</b>		3 half days a week or more
Psychiatry consultant	92% (24/26)	17% (4/24)
Psychiatry non-consultant	65% (17/26)	24% (4/17)
Psychology	46% (12/26)	58% (7/12)
Nursing	31% (8/26)	75% (6/8)
Psychotherapy	31% (8/26)	12% (1/8)
Family therapy	23% (6/26)	34% (2/6)
Psychiatric social work	19% (5/26)	20% (1/5)

(+): denominators vary to reflect non-response to some questions  
PICU = paediatric intensive care unit.

and generally included three or more weekly sessions. Other disciplines were involved in a third or less of services, mostly on the basis of one or more regular weekly sessions. Figure 1 shows the type of paediatric liaison work undertaken by different professional groups. Psychiatrists were involved more across most activities, especially so for emergency and consultation work and in teaching.

Responders were asked for their opinion on the service offered: two-thirds believed (one-third strongly) that they were providing a good liaison service and most 22/26 (85%) believed (12/26 or 46% strongly) paediatric liaison to be an important area on which to target CAMHS resources.

### Service planning and funding

Half the respondents (15/27 or 56%) reported that the mental health needs of paediatric patients had been discussed explicitly in a multi-agency advisory group with the local purchasing authority for mental health, and 11/27 (41%) had some form of service level agreement with paediatrics to provide a liaison service. A third (10/27 or 37%) had ongoing plans to develop liaison services, and 13/23 (56%) indicated that liaison services were funded by CAMHS, 2/23 (9%) by paediatrics, the rest being jointly funded.

Respondents were aware of other psychosocial support provision to their local paediatric hospital: two-thirds reported a separate social work, one-third psychology, and one-fifth a counselling service. The degree of coordination of these with the CAMHS liaison service was variable, one-third reporting lack of any co-ordination.

### Paediatric survey

The response rate by paediatricians was 19/30 (63%). Of the 19 responders, 8 (42%) were in teaching and 11 (58%) in district general hospitals. The median number of consultant paediatricians per service was 5 (quartiles 4; 11), the median paediatric beds 24 (20; 30) and the number of monthly admissions 210 (170; 300).

Results from paediatricians were broadly in keeping with those from the specialist CAMHS survey: 8/18 (44%) reported a regular liaison service from specialist multidisciplinary CAMHS, whilst the service was described as ad hoc in 10/18 (56%). Funding came from paediatric services in 1/15 (7%), but mostly it came from CAMHS (13/15 or 87%; jointly funded in 1/15 or 7%). In addition, paediatric responders reported a regular psychosocial support service from play therapists 15/17 (88%), social workers 12/17 (71%; ad hoc service from 3/17 or 18%), psychologists 5/16 (31%; ad hoc service from 2/16 or 12%) counsellors 2/16 (13%; ad hoc service from 6/16 or 37%). Also reported was ad hoc psychosocial support from psychotherapists 3/15 (20%). The paediatric budget covered the costs of virtually all play therapists 14/15 (93%), fewer covering the costs of psychologists 4/6 (67%) or counsellors 2/7 (29%) and even fewer social workers 1/14 (7%).

The types of problems paediatricians referred most commonly to specialist CAMHS and to other psychosocial support services are outlined in Table 4. Specialist CAMHS were the referral point for most mental

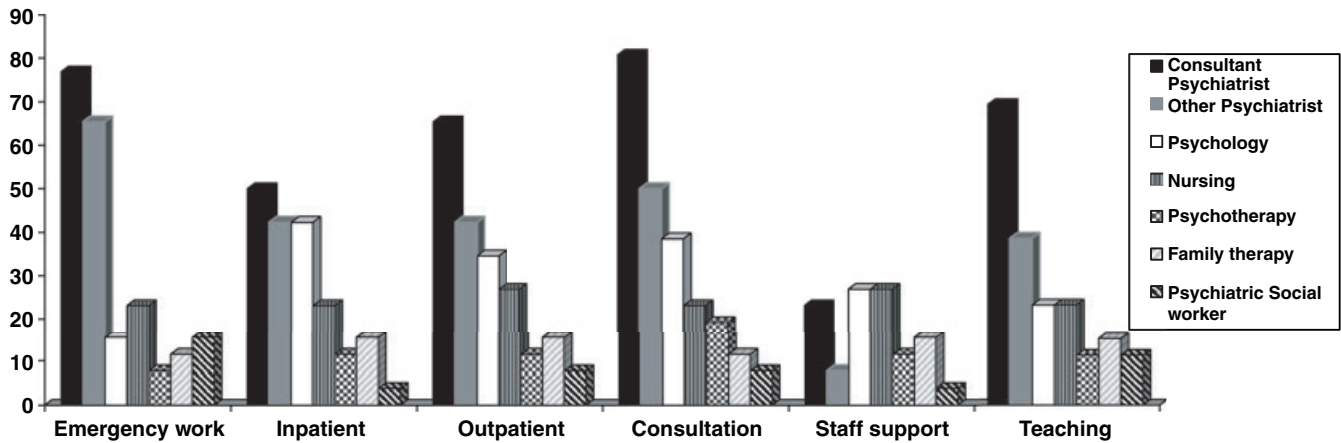


Figure 1. CAMHS survey: percentage of services with a particular professional group involved in different types of paediatric liaison work (n = 26)

Table 4. Paediatric survey: percentage of problems referred to specialist CAMHS and to other psychosocial support services (n = 19)

Percentage referring	Specialist CAMHS	Other psychosocial support services
100–70%	Psychosis (19/19) Depression (19/19) Eating disorders (18/19) DSH (18/19) ADHD (16/19) Conduct disorders (15/19)	Disturbed behaviour (15/19) Anxiety (15/19) Personality disorder (14/18) Stress/adjustment Disorders (13/17)
69–40%	Elimination disorders (12/18) Adjustment to physical illness (12/18)	Autistic spectrum (11/18) Somatoform disorders (9/18) ADHD (8/19) Autistic spectrum (11/18) Adjustment to physical illness (8/18)

DSH = Deliberate self-harm; ADHD = attention deficit hyperactivity disorder

health problems in children, especially for psychoses and depression, but also for somatoform, anxiety, and disruptive and other disorders. The only referral type to CAMHS noted by less than 40% was child abuse (6/17), whilst other psychosocial support services were more likely to be referred cases of abuse. The following were referred to these other psychosocial services in less than 40% of instances: elimination disorders (7 responders), stress/adjustment disorders, disturbed behaviour, eating disorders, conduct disorder (6 responders), personality disorder, deliberate self-harm, anxiety (4), and somatoform disorders (3). No respondents referred depression or psychosis to these services.

Whilst a comparable number to the specialist CAMHS survey respondents (two-thirds: 13/19 or 68%) agreed that they were receiving good support from specialist CAMHS and 10/18 or 55% reported good support from other psychosocial support services, only one-third (6/19 or 32%) felt that the mental health needs of paediatric patients were being met.

Virtually all (16/17 or 94%) wanted to develop further links with specialist CAMHS and 11/18 (61%) with other services (2 mentioned a wish for more social workers, 3 for more psychotherapists and 5 for more psychologists). The specific priorities for development are listed in Table 5. Again virtually all (17/19 or 89%) thought that mental health was an important area on which to target paediatric resources, whilst recognising (13/15 or 87%) that specialist CAMHS input was being funded by other than paediatric services. Half (10/19 or

Table 5. Paediatric survey: number and percentage of services reporting priorities for specialist CAMHS and for other psychosocial support services development (as one of their top four)

Priorities for increased work	Specialist CAMHS (n = 16)	Other psychosocial support services (n = 11)
Good access to outpatients	15 (94%)	8 (73%)
On call/emergencies	15 (94%)	8 (73%)
Liaison	11 (69%)	9 (82%)
Consultation	11 (69%)	5 (45%)
Joint OPD	4 (25%)	4 (36%)
Research	4 (25%)	2 (18%)
Teaching	3 (19%)	1 (9%)
Staff support	1 (6%)	6 (55%)

53%) of responders were aware of the existence of a multi-agency group advising the purchasing authority on the mental health needs of children and adolescents but only one-third (6/17 or 35%) knew whether the mental health needs of paediatric patients were discussed in this forum.

### Discussion

This British survey carried out in the Greater London area shows that, at the time of study, most specialist multidisciplinary CAMHS, whether community or hospital based, were providing some liaison work. Nevertheless, formalised liaison services were rare (provided

by only one-third) and dedicated specialist CAMHS liaison services even rarer. Nearly all CAMHS were providing a generic service through outpatient and emergency referrals, but closer or more specific liaison, such as joint outpatients and ward rounds, were reported by half or less. Appropriately, most liaison work was aimed at general paediatrics and A&E, but a number of specialist units such as PICU, haematology, oncology and neurology were also targeted for this work.

Whereas emergency referrals represented the hard face of disorders seen in CAMHS work, in line with previous surveys, those referred for assessment whilst on paediatric inpatient units were mainly adjustment to physical illness and somatoform disorders (Wrate & Kolvin, 1978; Black et al., 1999). These were also the main reasons for referral to CAMHS outpatients. Liaison CAMHS therefore need to have expertise in problems that are not otherwise the bread and butter of generic work. This includes not just an understanding of the connections between physical symptoms, health problems and mental health, and specific management skills for these. It will also involve a close appreciation of paediatric conditions and liaison with paediatric services (Taylor et al., 2003; Knapp & Harris, 1998). In addition to specialist referrals of this kind, a wider range of other psychiatric disorders were recognised and referred by paediatricians to specialist CAMHS outpatients, highlighting the fact that the latter fulfils not simply a potential liaison but also a more generic referral function.

Specialist CAMH services in this survey were providing a considerable amount of teaching to paediatricians, nurses and medical students, but this was an infrequent activity and might therefore only have token influence on the mental health aspects of paediatric practice. The importance of teaching doctors and other disciplines has been highlighted (Kurtz et al., 1994, Bass, Peveler, & House, 2001; Cockburn & Bernard, 2003; Slowik & Noronha, 2004). Less training is associated with less joint working with child mental health professionals (Fritz & Bergman, 1984). Our results suggest that careful thought needs to be given to where and how to prioritise paediatric training needs in this area.

Most specialist CAMHS liaison work was done by child psychiatrists. Nevertheless, this was mostly on an ad-hoc rather than regular basis, with other professionals providing more of a regular input. This may possibly be construed as psychiatrists 'plugging the gap' in historically poorly resourced services. With the increasing pressure for specialist CAMHS to liaise with educational and social services, there is a danger that paediatric liaison work may be 'squeezed out', unless adequately planned and commissioned for. This would leave a population of high need un-served. The importance of adequate dedicated funding for liaison services has been highlighted over the years in different countries (Wright et al., 1987). This is supported by the high health services costs generated by some of the problems addressed in this work and therefore by potential cost-effectiveness (Sheehan, 2002; Kush & Campo, 1998).

As in previous CAMHS surveys (Kurtz et al., 1994), we have found parallel development of specialist CAMHS multi-disciplinary and other psychosocial paediatric

support services, with both overlapping and differing expectations from paediatricians. The rationale for the development of these separate but overlapping services has received little consideration and it is unclear how they are being co-ordinated. They are usually managed and funded separately and this raises the issue of how comparatively under-provided services of this kind should be formally co-ordinated, in line with NSF recommendations (Department of Health, 2004), in order to avoid unnecessary duplication and/or mixed or differing messages being given to clinicians and families.

From our survey, it seems that services are already achieving some differentiation of tasks. The most common referral to non-specialist CAMHS psychosocial support services was child abuse, possibly reflecting the fact that, after play therapists, social services were the second most commonly reported service. Referrals to specialist CAMHS were primarily for child psychopathology, including specific liaison problems such as somatoform disorders and adaptation to physical illness. Referral overlap was most common for autistic spectrum disorders and, to a lesser extent, for problems in adjustment to physical illness, suggesting these as possible areas for service duplication; this is therefore where a concerted effort may need to be made to clarify roles.

Just as with referral patterns to specialist CAMHS and other psychosocial services, there was also an overlap in paediatric views as to the type of services they need to develop in order to meet the perceived needs of their patients. The priorities for further development listed by paediatric services indicate that whereas good access to specialist CAMHS out-patients and response to emergencies are seen as most pressing, staff support was a more common expectation from other psychosocial support services. This points to different and complementary ways ahead for both types of services. Specialist CAMHS might focus more on child psychopathology as it presents within the paediatric setting and as it affects physical health. Other services could put more of an emphasis on the social aspects of paediatrics and to staff counselling and support.

Our survey was based in one area in the UK, with heavy provision of teaching hospitals. Staffing provision was high when compared with that for the whole of CAMHS in England (Bradley et al., 2003). Even so, the findings are in line with those from Slowik and Noronha (2004) in the West Midlands, in documenting a perceived need for more accessible child psychiatric consultation services. Larger studies are required to clarify which aspects of service delivery allow the development of the minority of dedicated liaison services identified.

## Conclusion

Although only a minority of CAMHS provided a dedicated paediatric liaison service, some form of paediatric liaison CAMHS work was common. There is a commitment from both CAMHS and paediatricians to further develop this area but there are no apparent plans neither for co-ordinating specialist multidisciplinary CAMHS provision with other psychosocial services provision nor for earmarking of the necessary funding.

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