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Physical health of children and adolescents

What specialist child and adolescent psychiatrists need to know and do

Faculty of Child and Adolescent Psychiatry,
Royal College of Psychiatrists

FACULTY REPORT

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Introduction

A child and adolescent psychiatrist is a medically trained specialist with skills in the assessment, management and treatment of mental health problems, disorders and illnesses in children and young people under the age of 18. Like all psychiatrists, they are trained to integrate biological, psychological and social factors associated with mental health problems of this age group but also consider developmental and educational factors that might affect the child's clinical presentation (Royal College of Psychiatrists, 2014).

An important role of a child and adolescent psychiatrist is to conclude, through integration of the above components, on a formulation of a child's or a young person's mental health difficulties and advise on treatment and management strategies. A core element in this process is the consideration of physical health problems that can affect a child's or a young person's clinical presentation as well as monitoring and management of physical health consequences associated with proposed treatments.

This report aims to summarise the role and responsibilities of child and adolescent psychiatrists in relation to the physical health of children and young people under their care.

Competencies of child and adolescent psychiatrists

Child and adolescent psychiatrists' competencies are clearly defined in the curriculum for specialist training in child and adolescent psychiatry published by the Royal College of Psychiatrists in 2013. Physical health competencies are a significant part of specialist training.

In summary, as part of their training, child and adolescent psychiatrists need to be conversant with the physical health components of clinical presentations and treatments in child and adolescent mental health and as a result be able to:

1. consider the possibility of physical illness in a child or young person seen by them and include this in their differential diagnosis
2. conduct a physical examination across the age range of children and young people, including a neurodevelopmental/neurological examination, but also recognise their own limitations
3. request appropriate investigations
4. keep up to date with the effects, interactions and side-effects of prescribed psychotropic medication or medication prescribed in paediatrics with possible psychiatric side-effects
5. organise pre-medication physical work-up and lead on physical and laboratory monitoring of children and young people on psychotropic medication
6. recognise acute medical illnesses, including those needing urgent attention, and organise appropriate medical input
7. recognise the need for a more expert paediatric or general medical opinion
8. recognise the possibility of safeguarding concerns associated with physical symptoms or injuries and liaise with other agencies (social care, paediatrics) as appropriate.

Particular emphasis in relation to physical health is given to the child and adolescent psychiatrist being able to take into consideration the developmental and emotional needs of the child subject to physical examination and investigations and conduct these in a sympathetic way with appropriate chaperoning. In addition, they need to be able to recognise that specific diagnoses (e.g. eating disorders, where particular expertise in the management of common comorbidities

of low weight is needed (Royal College of Psychiatrists, 2012)) or treatments (e.g. antipsychotic medication) are associated with greater need for physical health monitoring. They also need to be able to consider that specific physical illnesses (e.g. epilepsy, Tourette syndrome) are associated with high levels of mental health problems and that physical illness is likely to present with psychiatric symptoms in some children and young people (e.g. in intellectual disability). Finally, the child and adolescent psychiatrist should practice within an evidence-based framework, using research evidence and clinical guidelines (e.g. National Institute for Health and Care Excellence (NICE) guidelines) where available and know where these are not available.

Overall, the child and adolescent psychiatrist needs to be familiar with the frequently complex interaction between physical and mental health and consider both in their day-to-day practice.

Practical considerations

In clinical practice, the way child and adolescent mental health services (CAMHS) operate in different regions and with different local care pathways determine to a large extent the way child and adolescent psychiatrists exercise their role.

Community CAMHS accepting referrals from general practitioners (GPs) are likely to follow different procedures than paediatric liaison teams or in-patient units and have different facilities and protocols to address the physical health needs of children and young people accessing their services. In addition, supervision arrangements of other clinicians within the multidisciplinary team are likely to differ between services. This is particularly relevant in the case of clinicians with less experience in physical aspects of mental illness who manage the care of children and young people not directly reviewed by the child and adolescent psychiatrist. However, all CAMHS will need to develop protocols that allow appropriate physical assessment and monitoring of all children and young people under their care.

Strong links with GPs

The GP has a vital role to play in the promotion of physical well-being and physical health monitoring; however, their contribution in relation to physical conditions affecting a child's psychiatric presentation or their role in the monitoring of side-effects of psychotropic medication in children should not be taken for granted. When a child or young person is referred to a CAMHS team by their GP, there is an understanding that physical conditions are not expected to affect their clinical presentation or that the child's or the young person's psychiatric presentation is not solely the result of an already identified physical condition. However, the child and adolescent psychiatrist needs to be able to explore further this possibility, liaise with the GP and refer to other specialists if necessary. Depending on local arrangements, physical examinations and investigations (e.g. electrocardiogram (ECG), blood investigations) can take place at the local surgery, local hospital or partly at the CAMHS base. Good links with GP practices are also necessary when there are shared care arrangements in relation to medication prescribing or monitoring under the overall guidance of a child and adolescent psychiatrist. Systems of automatic reminders can be set in place (e.g. to remind the clinician to repeat a metabolic screen of a young person on antipsychotics) or the GP may rely on reminders from CAMHS. The child and adolescent psychiatrist needs to be satisfied that the physical aspects of a child's or a young

person's presentation are covered and has overall responsibility for organising or conducting the pre-medication screens and physical health monitoring associated with psychotropic medication.

Strong links with paediatric and medical departments

Child and adolescent psychiatrists are expected to foster good working relationships with paediatricians and physicians of their local hospital. This will ensure timely and effective physical assessment and interventions in children and young people with physical health concerns, and facilitate targeted mental health input in children and young people presenting in local accident and emergency (A&E) departments or admitted to hospital wards. Collaborative working is particularly relevant to some clinical presentations (e.g. eating disorders, self-harm, acute confusional states, epilepsy, medically unexplained symptoms) where multi-specialist forums are likely to be necessary. It is also very important in cases where safeguarding concerns are likely to require close links across specialist teams, and where conducting and interpreting the results of physical investigations go beyond the expertise of the child and adolescent psychiatrist. The child and adolescent psychiatrist needs at all times to promote a holistic approach to the clinical presentation of children, young people and families under their care, liaising with colleagues who work in physical health as required.

CAMHS facilities

Expectations from a child and adolescent psychiatrist in relation to physical health monitoring of children and young people will depend to a large extent on the nature of their CAMHS base. In-patient units are more likely to organise physical examinations, assessments and investigations on-site. This would commonly involve conducting blood investigations and ECGs. Community CAMHS are less likely to have facilities for this range of investigations. However, it would be advisable for all CAMHS to have facilities allowing for physical examination (e.g. a dedicated room with an examination bed) as well as equipment for monitoring of height, weight and vital signs (including a sphygmomanometer with age-appropriate cuffs). This would allow for physical examinations to be conducted if necessary and for more efficient pre-medication work-up and monitoring of medication side-effects. Dedicated facilities for clinical examination in the CAMHS base are particularly important in certain conditions (e.g. eating disorders, intellectual disability) or certain medications (e.g. antipsychotics) to ensure that the physical health needs of patients are addressed sensitively in line with clinical guidelines. Links with local surgeries or hospital will be needed for blood tests and ECGs if these tests cannot take place in

the CAMHS base. Evaluation of ECGs is likely to require arrangements with local paediatric or general medical departments. Robust referral pathways, including access to GP care, paediatric or medical care and relevant investigations, need to be commissioned for children and young people with physical symptoms that go beyond the expertise of child and adolescent psychiatrists regardless of the CAMHS setting. The child and adolescent psychiatrist needs to coordinate this process and be satisfied that it is conducted in line with clinical guidelines.

Employing organisation's responsibilities

Employing organisations providing care to children and young people (National Health Service (NHS) trusts, local health boards) will need to support and facilitate the role of child and adolescent psychiatrists in relation to physical health monitoring and management of patients. This would normally include good links or service-level agreements with acute healthcare providers (paediatric or medical departments) or GPs for advice and guidance in the case of regularly undertaken investigations (e.g. ECGs, metabolic side-effects monitoring), or clear pathways for joint management of cases requiring both physical and mental health input. Clinical audits and service evaluations of the physical health monitoring and management of patients in line with clinical guidelines need to be regularly undertaken. Facilitation of continuous professional development (CPD) including yearly basic life support training of child and adolescent psychiatrists is also paramount in ensuring that child and adolescent psychiatrists can competently and confidently respond to emergencies and take on the tasks of physical evaluation, monitoring and management of children and young people under their care.

Conclusions

Physical health evaluation, monitoring and management of children and young people referred to mental health services are core elements of the role of child and adolescent psychiatrists. They need to be incorporated in CAMHS service provision, facilitated by employing organisations and regularly audited. CAMHS-based arrangements, shared-care agreements with GPs and good links with paediatric and medical teams are needed to ensure a holistic approach, likely to lead to optimal outcomes.

Appendix: Additional resources

Guidelines

National Institute of Health and Care Excellence (NICE) https://www.nice.org.uk/guidance

Scottish Intercollegiate Guidelines Network (SIGN) http://www.sign.ac.uk/guidelines/index.html

Physical examination

Devlin A (2003) Paediatric neurological examination. *Advances in Psychiatric Treatment*, **9**: 125–34.

National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents (2004) The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents. *Pediatrics*, **114** (suppl 1): 555–76.

Sharieff GQ, Rao SO (2006) The pediatric ECG. *Emergency Medicine Clinics of North America*, **24**: 195–208.

Wallis LA, Healy M, Undy MB, et al (2005) Age related reference ranges for respiration rate and heart rate from 4 to 16 years. *Archives of Disease in Childhood*, **90**: 1117–21.

Abnormal movement scales

- **Abnormal Involuntary Movement Scale (AIMS)**

  Guy W (ed) (1976) *ECDEU Assessment Manual for Psychopharmacology*. US Department of Health, Education, and Welfare.

- **Barnes Akathisia Rating Scale (BARS)**

  Barnes TR (1989) A rating scale for drug-induced akathisia. *British Journal of Psychiatry*, **154**: 672–6.

- **Simpson–Angus Scale (SAS)**

  Simpson GM, Angus JW (1970) A rating scale for extrapyramidal side effects. *Acta Psychiatrica Scandinavica*, **45** (suppl 212): 11–9.

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