**HOSPITAL MANAGEMENT OF PAEDIATRIC FUNCTIONAL SOMATIC SYMPTOMS**

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EDITORIAL

HOSPITAL MANAGEMENT OF PAEDIATRIC FUNCTIONAL SOMATIC SYMPTOMS (title)

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Short title: Management of functional symptoms

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Paediatric functional somatic symptoms (FSS) remain a little understood clinical problem. They are at the interface between somatic and psychiatric health, and as such rarely a priority for physical or mental health services and research. As a result we know little about how they are managed in practice. The paper by Tøt-Strate and colleagues (1) helps fill this gap for children with FSS sufficiently severe to lead to paediatric hospital admission. Through scrutiny of medical records and discussion with clinicians they identified children with FSS admitted in the course of one year to the paediatric department of a Danish Hospital with a number of paediatric subspecialty units, and they compared clinical features noted in medical records in those who were and were not referred to the local paediatric liaison child and adolescent mental health service (PL CAMHS). The paper is noteworthy because although subject to the limitations of case note reviews, the method of case identification was particularly rigorous and systematic.

The main findings are the small number of children with case-note-recorded and rigorously defined FSS admitted to specialist paediatric care, the indications of higher clinical severity in the small sub-sample referred to PL CAMHS, and the limited psychosocial information available in the paediatric notes, which leads the authors to conclude that there is a need to improve and systematise mental health referrals of children with FSS. The study provides an opportunity to reflect on the frequency, nature and hospital management of children with FSS and to consider ways in which this may be improved.

**Frequency of FSS:** Overall only 1% of one-year paediatric admissions were categorised as FSS and of those a quarter (16/60 or 26%) referred to PL CAMHS. The identification of FSS for the study relied on local hospital register information and may be expected to have under-estimated rates. It would certainly be of interest to conduct prospective studies of paediatric admissions to ascertain actual prevalence. Nevertheless the number of children with definite FSS referred to PL CAMHS is comparable to reported by a PL CAMHS service in a tertiary, specialized hospital in the UK (2)
indicating similar referral practices in departments with available PL CAMHS. On the face of it this
would place FSS in the category of rare disorders within current paediatric hospital practice and
therefore likely to require specialist help.

**Case severity in the referred group:** Appropriately children and young people with confirmed FSS
referred to PL CAMHS were more severely affected than the non-referred on a number of features.
They had more multi-symptomatic FSS and clinical investigations, as well as longer paediatric
admissions. Most referred children had co-morbid somatic disorders and psychiatric diagnoses
indicative of truly mind-body or psychosomatic disorders, making diagnosis and management
especially complex and rightly deserving of expert PL CAMHS psychiatric opinion. However symptom
duration in the referred group had been over 6 months in most children, in line with reports by
others that referrals to PL CAMHS can be protracted and possibly clinically and financially costly (3).
Whilst understandable in view of the scarce specialist services available, this highlights an area
worthy of improvement.

The finding that a significant number of referred children came from intact families is intriguing. A
predominance of intact families has also been observed amongst children with chronic fatigue
syndrome seen in specialist paediatric clinics (4). Tøt-Strate et al suggest that in the Danish study
this could be explained by parents living together being more reluctant to enter the family based
treatment programme offered by CAMHS. An alternative explanation could be that a lack of obvious
psychosocial stressors may lead to over-emphasis on medical aspects and investigations, thus
militating against giving early attention to more subtle but relevant stressors; paradoxically this
could contribute to increased severity.

**Paediatric management**

Many children with FSS in out-patient settings improve with paediatric consultations (5) and PL
CAMHS are still only available in selected hospitals, making the management of more severe FSS a
paediatric endeavour. Accordingly the main reason for referral to PL CAMMHS was inadequate treatment response and diagnostic clarification. However, has the time come for a change in practice?

- **Information about psychosocial aspects**

There is increasing evidence not only of frequent co-morbid psychopathology in children with FSS, but also of the central relevance of broader psychosocial child, family and environment factors, and of the potential efficacy of psychological treatments (6). Nevertheless Tøt-Strate et al noted that information on relevant psychosocial aspects was insufficient or lacking in many of the reviewed paediatric records. Symptom related impairment in particular was only mentioned in the notes of half the total sample of children with FSS and was a rare reason for referral, in spite of the fact that impairment is a key feature of comparatively severe multi-symptomatic complaints and somatoform disorders in children and that this can involve prolonged periods of school absence and social withdrawal. It is increasingly acknowledged that the assessment of FSS should not simply consist of the exclusion of possibly causative medical disorders, but include and record careful systematic enquiry into mental health function and into biopsychosocial features, namely the variety of contributing biological and psychosocial predisposing, precipitant and maintaining factors which are susceptible to psychiatric interventions and to the psychiatrically informed psychosocial rehabilitation provided by PL CAMHS (6).

- **Management strategies**

There were differences in the interventions provided by the paediatric department for the referred and not referred groups, most common in the latter being supportive family conversations by paediatric staff about possible problems regarding the child’s behaviour and family issues. More specific interventions were reported in the referred group: most had been seen by a psychologist, and/or had been offered physiotherapy, and nearly half had had sensory training, with guided exercises on body awareness, relaxation and breathing techniques. However the lack of response to
treatment leading to PL CAMHS referral suggests that these techniques were insufficient and that an earlier referral to PL psychiatry would have been appropriate.

- **Possible improvements**

Although only a quarter of children with FSS had been referred to PL CAMHS, it was noticeable that in a third of non-referred children symptom duration was as long as in the referred group, a quarter of non-referred children had multiple symptoms, half had co-morbid somatic morbidity and a fifth primary psychiatric diagnoses; in addition half displayed indications of reduced general well being with symptoms of fatigue and concentration problems. This would appear to indicate that many of these children merited referral to the PL CAMHS team for a full psychiatric and psychosocial assessment. Indeed, together with the limited psychosocial information noted it suggests that all children with FSS requiring paediatric admission could benefit from assessments by child psychiatrists and their PL CAMHS teams. An expectation that all these children are discussed with the PL-CAMHS should be helpful, as the Danish study found that 69% of those referred but none of the non-referred had been discussed at paediatric CAMHS liaison meetings during their admission.

**In conclusion** this paper documents a little investigated area of clinical practice and highlights areas deserving further action and scrutiny. As currently documented, the number of children with FSS admitted to paediatric hospital departments with specialist units appears comparatively small, but even so only a small percentage is referred for expert advice and the psychosocial information available on these children is limited. A case can therefore be made for the early referral of all paediatric in-patient FSS cases to PL CAMHS. This would help translate into paediatric practice the emerging knowledge on the relevance of psychiatric and psychosocial factors for the understanding and management of paediatric FSS. The hospital where this study was conducted is to be congratulated for supporting PL CAMHS and the study by Tøt-Strate et al (1), and in so doing leading the way for possible further developments in this field.
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