Children and young people with mental health issues admitted to the hospital: a toolkit for the general paediatrician

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Abstract

As the number of children and young people (CYP) attending the emergency department (ED) with a mental health crisis is increasing, it has become evident that neither the environment nor the training for general paediatricians is adequate to meet CYPs' mental health needs. This short article provides an essential toolkit for paediatricians and other healthcare professionals working with CYP. It provides a resource encompassing skills and knowledge to promote understanding of mental health crises and strategies to address these when CYP are in ED or admitted to the ward. It will allow general paediatricians to address the agitation and distress experienced by many CYP in EDs or on paediatric wards and use verbal de-scalation techniques rather than medications. The toolkit highlights how to take an appropriate mental health history, perform a mental state examination and if necessary medical investigations required, as well as providing an overview of the legal framework under which mental health conditions are managed in different age groups. A short section highlights the most common mental health issues and their management. Lastly, the CAMHS structure is explained to support the multi-professional collaboration needed to ensure CYP are managed appropriately between teams and have the best support and care possible in the ED and on paediatric wards.

Keywords BAGP; British Association of General Paediatricians; CAMHS; children and young people; de-escalation in mental health crisis; emergency department; general paediatrician; guidelines mental health disorders; legal framework for consent in children and young people; mental health; paediatric ward

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Introduction

Presentation of children and young people (CYP) with significant mental health issues to Emergency Departments (ED) and admission to paediatric wards is increasing[1,2] as is the frequency of 'psychiatric boarding', where patients remain either in ED or on a ward while awaiting placement or psychiatric admission.[3]

Research shows that often neither the physical environment in acute trusts nor medical training are appropriate to meet the needs of CYP with mental health issues. ED and paediatric ward staff report lacking skills in assessing and managing CYP mental health issues.[4,5] Often attendance in ED or admission can exacerbate distress during a mental health crisis.[1,4]

This toolkit is a response from the British Association of General Paediatricians (BAGP) to the needs of CYP in line with the recent statement from the Royal College of Paediatrics and Child Health (RCPCH): 'It has never been more important for paediatricians to recognize that the mental health of our patients is our business'[2]. It aims to provide general paediatricians with increased knowledge and skills to support and manage children and young people with mental health issues during their admission to paediatric wards and ED.

Understanding agitation and distress in context

Agitation in context

During admission with mental health issues, CYP often display agitation and distress independent of the underlying psychiatric diagnosis, which warrants practical de-escalation strategies rather than medications. Agitation and aggression in CYP most commonly result from feeling unsafe, and it is vital to understand factors that impact psychological safety. Table 1 summarizes some theories and their practical uses when de-scalation of CYP is needed.

Psycho-physiological interventions

Agitation and stress lead to psycho-physiological changes in the brain, body and behaviour. The sympathetic nervous system and the hypothalamic-pituitary-adrenal axis are activated during stress.[7,8] In turn, this results in a raised heart rate, rapid, shallow breathing, and observable Fight, Flight, Freeze, or Fawn (where the individual tries to minimize distress or danger by appeasing the threat) responses.

Engaging with CYP using PACE principles and the SAVE approach can help with verbal de-escalation and reduce the psycho-physiological changes (Tables 2 and 3).

Using TIPP Skills (Temperature, Intense Exercise, Paced Breathing and Progressive Muscle Relaxation; Table 4) allows us to work directly with the autonomic nervous system to slow the physical response often seen in crises.

Box breathing (Figure 1) relies on voluntarily slowing down the breathing, which slows the heart rate[7] and activates the parasympathetic 'rest and digest' system.

Mental health history and assessment

When assessing CYP in the ED or on the paediatric ward, the psychiatric history and Mental State Examination (MSE) are key to assessment and guide management. Box 1 identifies the 5Ps, which are used to summarize our understanding of the current

De-escalation practice development

Factors impacting psychological safety	Theory	Use of theory in practice
Adverse childhood experiences (ACE) and trauma	**Trauma theory** A significant number of CYP are exposed to adverse experiences such as poverty, domestic violence or sexual abuse.[6] A Trauma-Informed way of working assumes that CYP presenting with agitation and aggression may have experienced trauma and recognises the hospital environment might create further trauma.	**Trauma informed practice** As in BLS, assess the environment for 'hazards' - stressors — when supporting agitated or aggressive CYP Consider what 'safety' might look like for CYP in A&E or the ward: Do you have access to quiet spaces, sensory toys and tools, social stories, and de-escalation protocols? Commit to honesty over reassurance Find ways to collaborate with CYP
Families and systems	**Systems theory** It does not locate problems within an individual but sees CYP situated within multiple relationships and environments, depending on parents, teachers, and others to thrive. CYP are, therefore, sensitive to disruptions in their network. This was evident during Covid lockdown when many children struggled without the support of school and wider family systems.	**Working with systems** Always consider the systems around CYP in crisis — can they provide safety? Are they strong/fragile, extensive/absent, able to buffer against external stressors/actively stressful or abusive What role do we play in the system?
Disrupted attachments	**Attachment theory** This theory suggests that infants seek bonds with responsive caregivers. When caregivers' responses are misaligned, CYP may develop attachment anxiety or become avoidant. We may encounter unpredictable behaviours in patients and carers based on previous experience. Awareness of these patterns can help professionals respond skillfully to rejecting, abusive, or overly dependent reactions from CYPs and carers.	**Working with attachment** Note the quality of relationships between carers and CYP, including body language and verbal interactions. Is the carer able to make them feel safe? Reflect on a challenging interaction with a young person or parent: could attachment patterns be relevant?
Social and emotional development	**Social and emotional development**: As paediatricians we are used to assessing developmental motor functions. Assessing CYP's social and emotional development is equally important as it helps to communicate at their level and identify their current emotional and social developmental challenges. For example, a young person in secondary school may not engage with peers' interests but remain absorbed in imaginary games and struggle to manage puberty. CYP with less developed social and emotional skills may struggle to use reassurance or de-escalation strategies and might expect clinicians to know things without being told.	**Social and emotional development** What strategies do you use to calm younger CYP? Can you adapt these to work with older CYP who are emotionally less mature? Document evidence of developmental stage; e.g. understanding of 'Theory of Mind' (understanding other's beliefs and intentions), moral understanding, social awareness

Table 1

presentation, and Table 5 highlights the important factors that need to be covered by the MSE.

Learning difficulties and neurodiversity

Special consideration should be given to the needs of CYP with learning disabilities and/or neurodiversity.[13]

The SPACE model[14] focuses on five principles to support communication with these children. This model focuses on allowing more time, making information more accessible - short sentences, no medical jargon, written and illustrated information, checking to understand, adjusting the environment (longer appointments and sensory input) and finally

PACE: a trauma-informed way to deal with agitation and aggression[9]

P	**Playfulness** *'I can enjoy'*	Being playful creates a positive and calm atmosphere. Use games, role-play, story-telling and metaphors
A	**Acceptance** *'I can open'*	Shows you can see beyond behaviour. For example, a CYP may say, 'I know you hate me'. It is tempting to respond with 'That's not true' or 'Don't say that', but this may leave the child feeling that you really don't understand what it's like for them. We could respond with, 'I'm sorry you think I hate you; that must feel awful; no wonder you're angry with me.'
C	**Curiosity** *'I am understood'*	Brings understanding into behaviour. Being curious is different from asking the child, 'Why did you do that?'. Ask questions to discover, not to tell: 'I wonder if….?'; 'Could it be…?'; 'I am trying to imagine….'; 'Can you help me understand…?'.
E	**Empathy** *'My feelings are valid'*	Shows experiences are important to adults. Sentence starters - It sounds like it's been really tough… You have had lots of tricky times… I am so sorry it's been so hard for you… I can't even imagine how that was for you… I really want to hear how it's been for you…

Table 2

The SAVE approach

S	**Support**	'Let's work together…'
A	**Acknowledge**	'I see this has been hard for you.'
V	**Validate**	'I'd probably be reacting the same way if I were in your shoes.'
E	**Emotion naming**	'You seem upset.'

Table 3

demonstrating a physical examination on yourself or a carer (Figure 2).

Risk assessment

A detailed risk assessment is crucial when assessing CYP with mental health issues. An example of risk assessment following an overdose is seen in Box 2.

A good risk assessment includes:

- Historic risk — what happened in the past
- Demographics — high-risk group?
- Current risk — based on History and Mental State

Even the best risk assessment cannot predict the future, but it can inform the management plan, such as whether the CYP should be admitted or discharged and under what level of supervision. CYPs can be ambivalent about their reasons for taking overdoses or self-harming, and these can change (see Box 3).

All young people presenting after self-harm or a suicide attempt should have a mental health assessment before discharge. If there is evidence of ongoing active planning/attempts to self-harm, then they should be closely monitored pending assessment and consideration given to a legal framework for managing attempts to leave the hospital.

TIPP skills

T	**Temperature** Putting your face in iced water up to the ears stimulates the carotid baroreceptors and slows the heart rate by up to 20 bpm (use a sats probe to demonstrate). Putting a hand in iced water is less effective but still works.
I	**Intense Exercise** Reduces the mismatch between heart rate and metabolism and is a potent distractor reducing agitation, anxiety and distress
P	**Paced Breathing** Slowing breathing, e.g. box breathing — see below
P	**Progressive Muscle Relations/body scan** CYP can guide attention while 'scanning' different parts of the body. They will notice, breathe into, and relax their body while 'scanning'[10,11]

Table 4

Legal framework for treatment in the UK

All clinicians working with young people need to understand the legal frameworks for treating children and young people who are not consenting to treatment. If appropriate, advice from CAMHS, trust solicitors, and senior clinical and operational staff should be sought.[15]

Consent and capacity, 16 and 17 year olds

In UK law, young people aged 16 or 17 are presumed to be able to consent to medical treatment. However, a court order may override their refusal of treatment (it is unwise to rely on parental consent).

Assessment of mental capacity: if a young person lacks the ability to consent, a legal capacity assessment can be conducted, and the person may be treated under the Mental Capacity Act 2005, which applies from the age of 16. However, if treatment is required for a mental health disorder, the Mental Health Act is the more suitable legal framework (see Table 6).

Capacity means the ability to understand information and make decisions about your life.

The mental capacity assessment (see Box 4) should be documented clearly, noting the steps taken to support understanding, retention and use of the information, e.g. easy read or social story.

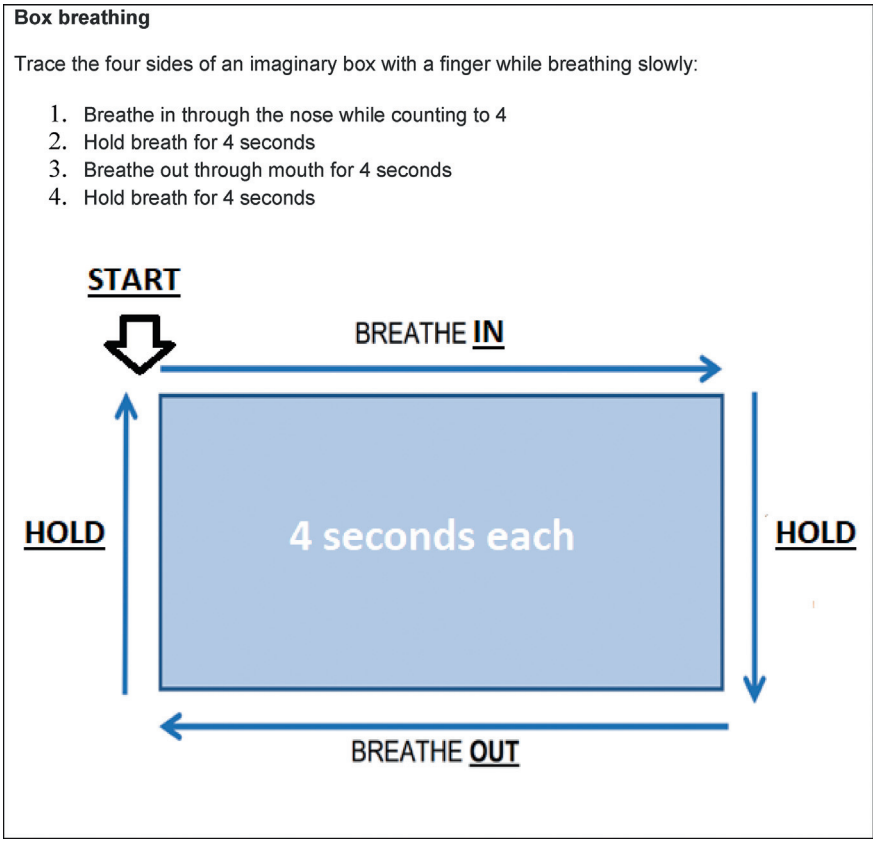

Figure 1 Box breathing as psycho-physiological intervention.

The 5 Ps formulation of difficulties

1. Presenting symptom(s)
2. Predisposing factor(s) — e.g. family history, upbringing, chronic ill health, neurodiversity, SEN conditions
3. Precipitating factors(s) — any recent triggers, e.g. bullying
4. Perpetuating factor(s) — e.g. ongoing stressors, poverty
5. Protective factor(s) — e.g., supportive family/friends, spiritual beliefs

Box 1

Consent and competence assessment under the age of 16 years

CYPs under 16 must demonstrate competence ('Gillick Competence'; Box 5) to consent to treatment. If a young person refuses or lacks competence, someone with parental responsibility can consent to treatment within the zone of parental control (Children Act 1989).[17] In certain circumstances, treatment can also be authorized by court order. Where treatment would involve a decision that a parent would not usually be expected to make, e.g. restraint for refeeding for Anorexia Nervosa, then the Mental Health Act (1983) might be a more appropriate legal framework for treatment; there is no lower age limit for the Mental Health Act.

There is no lower age limit to competence, but it becomes harder with decreasing age to demonstrate the emotional and intellectual maturity to make complex decisions about health care. Assessing competence follows the guiding principles below. Additional consent by a person with parental responsibility is not required.[18]

Emergency treatment

Emergency treatment without consent can be given to save the life of or prevent serious deterioration in the health of a child or young person, pending a more robust legal framework being put in place. Decisions should be made according to 'Best Interest' and 'Least Restrictive' principles.

Treatment under the Mental Health Act

Where a young person needs treatment for a mental health disorder, does not consent, or is not competent to give consent, and the decision is judged to be outside the zone of parental control, then the Mental Health Act (1983) is the most appropriate legal framework for treatment. This is sometimes referred to as 'being sectioned' (see Tables 6 and 7).

Young people cannot be detained in the ED, as it is not a ward but a public area, but they can be detained in a paediatric ward. The section paperwork has to be delivered to the hospital managers (usually the site manager) for the young person to be legally detained. When talking to parents/carers it is useful to provide written information. Leaflets regarding the individual sections and legal challenges can be found on the website of the East London NHS Foundation trusts in multiple languages using QR codes.[20]

An ABC… of mental state examination[12]

Appearance	Personal hygiene: any signs of self-neglect?
	Clothing: are they dressed appropriately for the weather/circumstances?
	Physical signs of underlying difficulties: any self-harm scars
	Stigmata of physical disorder
	Weight: significantly underweight or overweight? Weight for height?
	Objects: have they brought any objects with them? What are they?
Behaviour	Eye contact
	Facial expression
	Body language
	Psychomotor activity, e.g. restlessness
	Abnormal movements or postures (e.g. tics, tremors)
Cognition	Orientation for time, person and place
	Registration - the ability to repeat new information, e.g. a name and address
	Recall - remembering the new information five minutes later
	Concentration and attention - spelling WORLD backwards or serial sevens
	General knowledge — which school do they go to
Delusion	Unshakeable idea or belief out of keeping with the patient's educational, cultural and social background
Expression: speech	Rate
	Quantity (e.g. paucity, excessive, etc.)
	Volume
	Fluency and rhythm
Feelings: mood	Low or elated
	Anxious, angry, guilty etc
Gaining insight	Insight, 'What do you think the problem is?
	What treatment would help?
Harm/risk	Risk to self
	Risk to and from others
Ideas/thoughts	Thoughts form — speed, flow
	Content, e.g. cohesion

Table 5

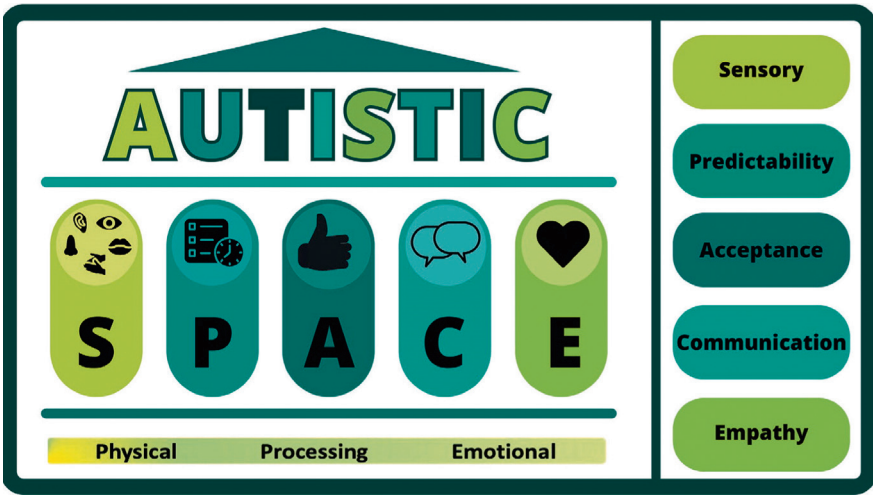

Figure 2 SPACE model (Sensory needs, Predictability, Acceptance, Communication and Empathy). Reproduced from reference 14 under the Creative Commons CC BY 4.0 license.

Example risk assessment after self-harm/overdose

Start with open questions:
'I understand you took some tablets yesterday. Can you tell me what happened?'

Before

- Prior events: explore any possible triggers, at school or home, and previous attempts
- Thinking: 'How long have you been thinking about suicide? How long have you been planning to take an overdose?'
- Precautions: 'Did you tell anyone?'
- Preparation: 'Did you write a note?'

During

- Sequence: 'Can you tell me what happened?'
- Substances: 'Did you take anything else?' (alcohol or drugs)
- Expectations: 'What did you expect to happen?'

After

- Regret: 'How do you feel now?'
- Lingering thoughts: 'Have you had thoughts while in hospital?'
- Future: 'What are your plans?' 'What would you like to happen now?'

Box 2

Typical examples of CYP narrative following self-harm

'It's a way to have control over my body because I can't control anything else in my life'
'I feel relieved and less anxious after I cut. The emotional pain slowly slips away into the physical pain'.
'At least if I feel pain, it's better than feeling nothing'
'I don't want to be dead, but I don't want to be here'

Box 3

Mental health conditions

Some mental health disorders, such as psychosis or eating disorders, require joint physical and mental health assessment and management. Understanding each other's roles and

Mental capacity assessment of CYP over the age of 16 years[16]*

There are five key principles of the Mental Capacity Act.[16]

1. A presumption of capacity
2. Individuals are supported to make their own decisions
3. Right to make unwise decisions
4. Any decision taken must be in the person's best interest
5. Least restrictive option

The Mental Capacity Act applies whenever:

- There are doubts over the ability of a young person (from the age of 16) to make a particular decision at a particular time
- The young person has an 'impairment of' or a 'disturbance in' the functioning of the mind or brain.

Intact capacity requires that:

- The person can understand all of the relevant information
- The person can retain the relevant information long enough to make a decision
- The person can use or weigh up the information to make a decision
- The person can communicate their decision by any means

*Key legislation and relevant practice guidance: Mental Capacity Act 2005; NICE Quality Standard: Decision-Making and Mental Capacity.

Box 4

Assessment for Gillick competence of CYP under the age of 16 years[17]

1. The person understands the nature and implications of the decision and the process of implementing that decision: this is the most important part of the process
2. Understand the implications of the option not pursuing the decision
3. Retain the information long enough for the decision-making process to take place
4. Weigh up the information and arrive at a decision
5. Communicate that decision.

Box 5

Legal frameworks for consent and treatment for mental health disorders according to age groups

Age	CYP ability to consent to all treatments	CYP ability to refuse all treatments	Assessment of capacity to consent	Legal framework
≥18 years	Yes	Yes	Same as 16–18 years Mental capacity assessment for emergency treatment Treatment for mental health disorders	Mental Capacity Act 2005 Mental Health Act 1983
16–18 years	Yes	No	Mental capacity assessment for emergency treatment Treatment for mental health disorders	Mental Capacity Act 2005 Mental Health Act 1983
<16 years	Yes, if competent	No	CYP Gillick competence	Children Act 1989 Mental Health Act 1983

Table 6

Summary of the legal framework in the UK[19]

Section	Purpose and criteria	Criteria	Duration	Process
Section 2	Hospital admission for assessment and treatment	CYP suffering from a mental disorder of such a nature or degree that there is no less restrictive option than detention for assessment ± treatment, for the health or safety of CYP, or the safety of others	28 days	Assessment by 2 independent doctors, either separately or together, one of whom must be S12 approved, together with an Approved mental health practitioner (AMHP)[a] Two medical recommendations for detention, an application by the AMHP, and an identified bed on a named ward are needed for section paperwork to be completed
Section 3	Hospital admission for treatment.	CYP suffering from a mental disorder of such a nature or degree that there is no less restrictive option than detention for assessment ± treatment, for the health or safety of CYP, or the safety of others	6 months, can be extended for another 6 months, then a further year if necessary	Assessment by 2 independent doctors, either separately or together, one of whom must be S12-approved , together with an Approved mental health practitioner (AMHP)[b] Two medical recommendations for detention, an application by the AMHP, and an identified bed on a named ward are needed for section paperwork to be completed
Section 5(2)	Emergency detention: MHA assessment must be requested at the earliest possible opportunity.	CYP must already be an inpatient with a possible mental health disorder requiring further assessment and concern about their safety if they were to leave the ward; provides robust legal framework for detention but not treatment	72 hours	On a paediatric ward, the responsible paediatric consultant or their representative (usually the on-call Core Trainee) completes the S5(2) form.
Section 4	For emergency admission for assessment.	As in section 2, in a genuine emergency, where the need for admission is too urgent to wait for a second doctor	72 hours max.	One doctor recommendation (section 12 approved, usually CAMHS clinician), the AMHP making the application must have seen the YP in the prior 24 hours and agree that getting a second doctor assessment would cause undesirable delay Rarely used

[a] One of the doctors must be a mental health specialist approved under section 12; ideally, one doctor must be familiar with the patient. The two assessments must be no more than 5 clear days apart (meaning if the first was done on a Monday, the second must occur no later than the next Sunday).
[b] In this case, the nearest relative must be consulted before the application (not just informed), and the application cannot proceed if they object. As with Section 2, the two assessments must be no more than 5 clear days apart, and the YP must be admitted within 14 days of the last medical recommendation.

Table 7

collaborating closely with CAMHS, psychologists, and other mental health professionals has led to better outcomes. Below are examples of a few conditions highlighting some key issues that have proven helpful in clinical management. Table 8 gives a selection of guidelines on some conditions frequently seen in general paediatrics.

Self-harm and emotional dysregulation

Self-harm is a behaviour that may be a way of coping with feelings or situations or expressing distress. It is important to ask about the intention of the act and assess the severity of injury when assessing risk. This will help to differentiate between accidental, self-harm or suicidal intention. As a general paediatrician, understanding the risk factors and intention does not replace a detailed CAMHS assessment but promotes effective risk management. Feedback from CYP is that language such as 'deliberate', 'superficial', or 'attention seeking' is experienced as dismissive.

Eating disorders

The incidence of eating disorders is increasing. It is important for paediatricians to be able to identify them, particularly in the early stages when CYP may look healthy. Key skills for managing anorexia nervosa include assessment of the risk of refeeding syndrome and providing medical care for CYP, both of which are outlined in the MEED guidelines. The MEED guidelines has replaced the previous Marzipan guidelines.[23]

The MHA can be used as a legal framework for NG feeding if a CYP does not consent.[23] Nasogastric tube (NG) feeding under restraint should be a carefully considered decision, made on a case-by-case basis, jointly by the eating disorders team and paediatrician. This decision should be made using the least restrictive methods to avoid causing trauma to the patient and those in their surroundings. Working collaboratively with CYP and their families remains essential even in these difficult circumstances. Dietetic guidelines have been created to outline the best practices for providing enteral nutrition under restraint.[23]

First episode psychosis

CYP presenting with a first episode psychosis should be carefully assessed by a paediatrician and a psychiatrist to make a working diagnosis and differential, considering:

- Onset and evolution of bizarre behaviour, delusions or hallucinations (sudden or gradual)
- Evidence of prodromal period of social withdrawal and impaired ADLs
- Presence or absence of neurological signs and symptoms, recent fever or infection
- Family history of psychosis, cannabis use
- HEADSS screen (Table 9).

It is vital to exclude physical causes of psychosis. Where there is a characteristic history of prodrome and gradual onset of psychosis, baseline investigations should include (Table 10):

HEADSS assessment relevant to CYP presenting with first episode of psychosis

Home and environment	May identify stressors and risk factors
Education and employment	Ascertain changes in academic ability and behaviour in settings outside home
Activities	Withdrawal from activities may reveal negative symptoms
Drugs	Screen for drugs as current or historical risk
Sexual health	Peer relationship difficulties may indicate personality change
Suicide and depression	Mood disorders may be secondary to psychosis, or associated with it

Table 9

Selection of guidelines for selected mental health conditions commonly seen admitted to the general paediatric ward

Eating disorders	Anorexia nervosa Bulimia Binge eating Other specified feeding or eating disorders (OSFED) Avoidant/restrictive food intake disorder (ARFID)[21]	Eating disorder: Recognition and management; updated 2020[22] MEED Medical Emergencies Eating Disorder[23]
Self-harm	Intentional self-poisoning or self-injury, irrespective of suicidal intent	Self-harm: assessment, management and prevention of reoccurrence[24] Help for suicidal thoughts[25]
Anxiety	Anxiety disorders	Anxiety for Children and Young People[26]
Depression	Depression, Low mood disorder	Depression in Children; NICE 2019[27]
Psychosis	Schizophrenia, schizoaffective disorder, delusional disorders e.g. psychosis	Psychosis and schizophrenia in children and young people: recognition and management NICE guideline[28]
Bodily distress symptoms	Functional syndromes and somatoform disorders	Bodily Distress Symptoms in Children and Young People[29]

Table 8

Investigations to be performed when assessing a potential first episode of psychosis

12-lead ECG	Screens for cardiac structural and rhythm abnormalities before treatment. May provide circumstantial evidence for drug intoxication.
Urine dipstick	Exclude UTI
Full blood count	Baseline before treatment; may indirectly evidence nutritional deficiency
ESR	Chronic inflammatory state
Electrolytes, liver and bone profile	Baseline before treatment; may be evidence of underlying cause (e.g. hypoadrenalism or hypercalcaemia).
CRP	Acute inflammatory state
TSH, free T4	Hyper- or hypothyroidism
Copper and caeruloplasmin	Wilson's disease
ANA	Autoimmune screen
Blood gas	Blood lactate may be raised in metabolic disorders, status epilepticus, disorders of acid-base balance, drug intoxication, and carbon monoxide poisoning.
Vitamin B12, folate	B12 deficiency
Vitamin D	Psychosis is associated with low vitamin D
Lipid profile, prolactin, glucose and HbA1c	Baseline before treatment

Data from reference 28.

Table 10

Where the presentation is more acute and/or there is concern about confusion, seizures, or neurological signs, urgent CT head/MRI brain, EEG, and LP, with further antibody tests (e.g., VGKC complex (anti-LGI1 and Caspr2), NMDA receptor, GAD, AMPAR, and GABA antibodies), may be indicated.

Bodily distress syndrome

The term bodily distress syndrome (BDS) describes a variety of symptoms, from pain anywhere in the body to loss of function, which cannot be explained with physical examination or any investigations.[29]

It is important to consider BDS when symptoms seem disproportionate, result in significant school absence, are seen across generations and lead to an unusual amount of contact with health professionals or a very high level of investigation. There may have been a prior illness that has led to ongoing symptoms that are out of proportion.

Health professionals often feel pressured to refer to other health professionals or perform further investigations. It's crucial to communicate these uncertainties with parents early on. Additionally, it helps to communicate that further investigations aim to rule out serious illnesses rather than confirm a diagnosis.

RAIN model: coaching patients and families through uncertainties[31]

R	Resistance/ reassurance /reality	Explore their concerns. Share your uncertainties about their condition with the CYP and their family. Do not focus on finding a diagnosis Symptoms are real	What are you worried about? What are you afraid what will happen? What do you think will help? What is difficult to do? ABC of Barriers: **A**ttitude — 'I don't go till symptoms are gone' **B**eliefs — 'Something is seriously wrong'. **C**ulture — 'Only a doctor can help' **D**rugs — 'Only medication will help' **E**nvironment — lone parent? poverty? **G**enerational BDS?
A	Anticipation	Listen, what do CYP and family hope for and want	What do you hope for? What do you think you need? What needs to happen in order to get better?
I	Investigations/ information	What information and investigations will help the CYP & family to accept symptoms and/or diagnosis of BDS?	Rule out the principle of serious diseases? Focus on symptoms, not diagnosis
N	Negotiation	What can CYP and family do? What can health services offer?	Emphasise 'symptoms are real' Embrace the reality of symptoms Are you open to speaking to CAMHS/Psychology/ counsellor?

Table 11

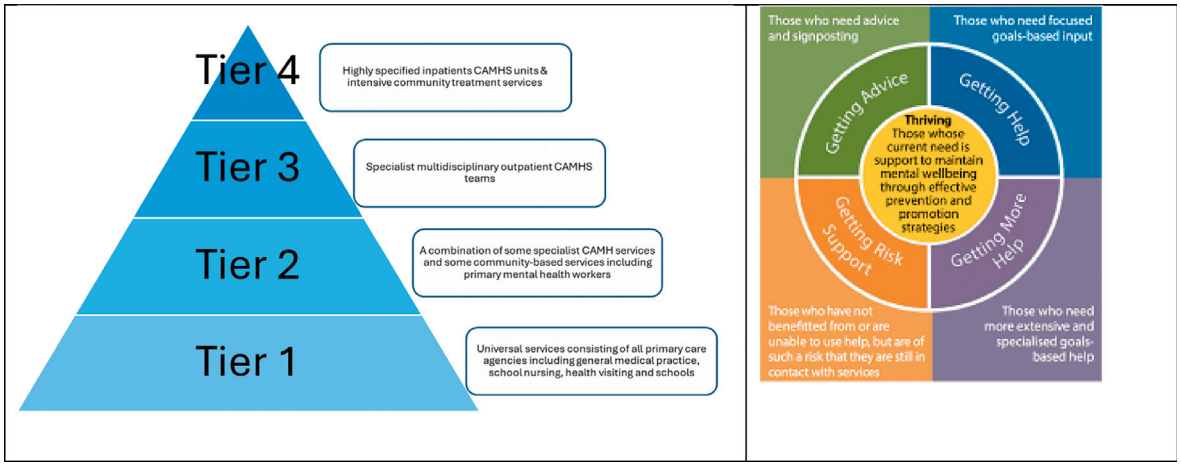

Figure 3 CAMHS structure. Left panel: adapted from reference 32; right side: reproduced with kind permission of the THRIVE framework.

Furthermore, there is often a delicate balance between addressing parents' and CYP's anxiety regarding an underlying serious disease and setting boundaries for professionals conducting additional investigations. Managing BDS requires a multi-professional approach involving CAMHS, counsellors, therapists and other health professionals.

It is extremely useful to communicate to the CYP and family that a multi-professional team decision supports the management discussed. Applying coaching principles means that CYP and their families can bring in their experiences and understanding[30]. Below is the RAIN model (Table 11), which can be used to coach patients and families through the uncertainty experienced in BDS and provide insight and empowerment[31].

CAMHS structures

Children and young people under 18 with mental health disorders may be referred to Child and Adolescent Mental Health Services (CAMHS) by schools, GPs, acute trust staff, and social workers. Understanding the CAMHS structure is helpful when working closely with them as a general paediatrician.

CAMHS services are organized in many areas using a 4 Tier model (Figure 3).

Most CAMHS teams are multi-disciplinary, consisting of psychologists, family therapists, and mental health nurses, with psychiatrists working predominantly in Tier 3 and Tier 4 services. Some CAMHS teams are located within the NHS, but Local Authorities and other organizations provide other services. Community Tier 3 CAMHS teams can be general or specialist, such as eating disorders or learning disabilities teams. Tier 4 community CAMHS teams can provide more intensive support to avoid inpatient admission. Admission to a General Adolescent Unit is not usually in CYP best interests, and most CYP are cared for in the community.

Most acute trusts have a CAMHS Crisis or Urgent Care Team that assesses young people presenting to the ED with mental health crises. These teams are usually the best point of contact with local community CAMHS teams. Some hospitals also have paediatric liaison services that can work with young people with functional disorders or complex physical and mental health conditions. When admitted to the ward, a registered mental health nurse (RMN) or mental health support worker (MHSW) may support CYP.

CAMHS services are increasingly moving towards the THRIVE Framework for system change[32] (see Figure 3), but the Tier model is still commonly used.

Conclusion

When CYP are asked about what matters to them when being assessed in ED or paediatric wards, they say kindness and non-judgemental compassion rather than knowledge about mental health issues. This is of paramount importance when assessing and supporting CYP with mental health issues, even when these seem overwhelming. It is vital to understand and listen to what CYPs and their families experience, as this should inform our communication.

There is an urgent need for investment in the CAMHS service. Through better funding, the CAMHS service can focus on prevention and resilience, which will, in return, reduce the number of CYP presenting to ED in crisis.[33] The NHSlong-term plan aims to improve access to community mental health services and expand mental health support teams in schools and colleges. It recognizes that ED is not an ideal environment for young people, recommending more crisis and liaison provisions and new 'crisis cafes' and 'safe havens'.[34]

However, 'crisis cafés' and 'safe havens' cannot completely substitute ED, and some CYP in mental health crises will continue to attend for physical and mental health assessment and treatment. This toolkit aims to provide frameworks and tools to support joint working to improve outcomes and care for CYP with mental health issues.

To improve the health outcomes of children and young people, the focus needs to be on building teams around CYP and their families, integrating different health teams through collaboration beyond simple care coordination. Current studies are looking at improving the health outcomes of CYP admitted to the ward[35] and raising awareness to improve the ward environment.[36] The toolkit aims to provide frameworks and tools to address mental health issues in CYP and to stimulate thinking to improve outcomes and care of CYP with mental health issues. ◆

REFERENCES

1 Vázquez-Vázquez A, Smith A, Gibson F, et al. Admissions to paediatric medical wards with a primary mental health diagnosis: a systematic review of the literature. *Arch Dis Child* 2024; **109:** 707–16.

2 Royal College of Paediatrics and Child Health. The role of paediatricians in children and young people's mental health - position statement 2024. *RCPCH* 2024, https://www.rcpch.ac.uk/resources/role-of-paediatricians-child-mental-health-position (accessed 20 July 2024).

3 Ibeziako P, Kaufman K, Scheer KN, et al. Pediatric mental health presentations and boarding: first year of the COVID-19 pandemic. *Hosp Pediatr* 2022; **12:** 751–60.

4 Cadorna G, Vera San Juan N, Staples H, et al. Review: Systematic review and metasynthesis of qualitative literature on young people's experiences of going to A&E/emergency departments for mental health support. *Child Adolesc Ment Health* 2023; **29:** 266–75.

5 Hudson LD, Chapman S, Street KN, et al. Increased admissions to paediatric wards with a primary mental health diagnosis: results of a survey of a network of eating disorder paediatricians in England. *Arch Dis Child* 2022; **107:** 309–10.

6 Petruccelli K, Davis J, Berman T. Adverse childhood experiences and associated health outcomes: a systematic review and meta-analysis. *Child Abuse Negl* 2019; **97**: 104127.

7 Zaccaro A, Piarulli A, Laurino M, et al. How breath-control can change your life: a systematic review on psycho-physiological correlates of slow breathing. *Front Hum Neurosci* 2018; **12**.

8 Garcia Pages E, Arza A, Lazaro J, et al. Psychosomatic response to acute emotional stress in healthy students. *Front Physiol* 2023; **13**: 960118.

9 bMindful Psychology. Understanding the PACE model. 2023. Available at: https://www.bmindfulpsychology.co.uk/post/understanding-the-pace-model (accessed 18 June 2024).

10 Anxiety Canada. Body scan script (Child/Teen). Available at: https://maps.anxietycanada.com/wp-content/uploads/2019/03/ABC_4118_Body_Scan.pdf (accessed 15 June 2024).

11 Nance AJ. Rhyming body scan for young children mindful arts in the classroom. Greater Good in Education, 2019.

12 Leach M. ABC of mental health history, 2024. unpublished material.

13 General Medical Council. Learning disabilities - professional standards. Available at: https://www.gmc-uk.org/professional-standards/ethical-hub/learning-disabilities (accessed 18 June 2024).

14 Doherty M, McCowan S, Shaw SC. Autistic SPACE: a novel framework for meeting the needs of autistic people in healthcare settings. *Br J Hosp Med* 2023; **84:** 1–9.

15 NHS England. Supporting children and young people (CYP) with mental health needs in acute paediatric settings: a framework for systems, 2022.

16 The British Psychology Society. Supporting people who lack mental capacity: a guide to Best Interests Decision Making, 2021.

17 NSPPC. Gillick competency and Fraser guidelines, 2022.

18 NSPCC Learning. Gillick competencies and fraser guidelines. 2022. Available at: https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines#heading-top (accessed 11 June 2024).

19 GOV.UK. Admission to hospital forms for use under the Mental Health Act. 2020. Available at: https://www.gov.uk/government/publications/admission-to-hospital-forms-for-use-under-the-mental-health-act (accessed 11 June 2024).

20 NHS East London Trust. Mental health act leaflets. 2023. Available at: https://www.elft.nhs.uk/health-professionals/mental-health-act-leaflets (accessed 17 June 2024).

21 BEAT. Types of eating disorders. 2024. Available at: https://www.beateatingdisorders.org.uk/get-information-and-support/about-eating-disorders/types/ (accessed 15 June 2024).

22 NICE. Overview. Eating disorders: Recognition and treatment. Guidance. NICE, 2017.

23 Royal College of Psychiatrists. Medical emergencies in eating disorders: guidance on recognition and management (replacing MARSIPAN and junior MARSIPAN), 2023.

24 National Institute for Clinical Excellence. Self-harm: assessment, management and preventing recurrence, 2022.

25 NHS. Help for suicidal thoughts. 2024. Available at: https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/help-for-suicidal-thoughts/.

26 Royal College of Psychiatrists. Anxiety for children and young people, 2022.

27 National Institute for Health and Care Excellence. Overview| Depression in children and young people: identification and management. Guidance. NICE, 2019.

28 NICE. Psychosis and schizophrenia in children and young people: recognition and management, 2016.

29 Royal College of Psychiatrists Child and Adolescent Faculty (RCPsych, CAP), Paediatric Mental Health Association. Bodily distress syndrome, 2022.

30 King G, Graham F, Ahkbari Ziegler S. Comparing three coaching approaches in pediatric rehabilitation: contexts, outcomes, and mechanisms. *Disabil Rehabil* 2024; **46:** 2708–19.

31 Leach M. Coaching patients through uncertainty, 2023. Unpublished material.

32 Wolpert M, Harris R, Hodges S, et al. THRIVE elaborated. 2015. Available at: https://implementingthrive.org/wp-content/uploads/2016/09/THRIVE-elaborated-2nd-edition.pdf.

33 Fazel M, Soneson E. Current evidence and opportunities in child and adolescent public mental health: a research review. *J Child Psychol Psychiatry* 2023; **64:** 1699–719.

34 NHS website. NHS long term plan - children's and Young people mental health. 2024. Available at: https://www.longtermplan.nhs.uk/areas-of-work/mental-health/children-and-young-peoples-mental-health/ (accessed 15 June 2024).

35 Hudson LD, Vázquez-Vázquez A, Gibson F, et al. Mental Health Admissions to Paediatric Wards Study (MAPS): protocol of a prospective study of mental health admissions to paediatric wards in England using surveillance and qualitative methods. *BMJ Paediatr Open* 2024; **8**.

36 Health Services Safety Investigation Body. Interim investigation report: keeping children and young people with mental health needs safe: the design of the paediatric ward. 2024. https://www.lenus.ie/bitstream/handle/10147/641486/mental%20health%20commission%20independent%20reviews%20of%20camhs%20services%20in%20the%20state%202023.pdf?sequence=1; (accessed 16 June 2024).

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