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EDITORIAL

# Physical comorbidity in mental illness in paediatric population: need for an integrated health care approach to paediatrics and child psychiatry

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It has long been recognised that adult subjects with severe mental disorders have more medical needs than the general population. In many instances, this is paired with greater difficulties accessing health care services, constituting an added burden to the mental disease. Mental disorders are complex disorders that often affect not only the brain, but also other parts of the body. This, along with other factors such as more common unhealthy life styles, may be one of the causes that explain the higher medical morbidity in subjects with mental disorders. It is also clear that difficulties in detecting and correctly diagnosing them are an added problem in patients who have cognitive impairments, are disorganised, have verbal communication problems, have a higher pain threshold, complain of atypical symptoms, and experience difficulties describing subjective experiences and symptoms.

This is also the case for children and adolescents with mental disorders. For instance, at least half of children with anxiety disorders may have a comorbid physical illness—most commonly allergies and asthma [1]—and up to 80% of children suffering from autism spectrum disorders suffer from gastrointestinal disorders, sleep disorders or epilepsy [5]. In addition, in many cases, behavioural problems, active lack of cooperation, and difficulties helping with differential diagnoses make the detection of a physical disease difficult for paediatricians. The side effects of psychotropic drugs are another cause for increased medical morbidity in this paediatric population. This has been clearly shown with antipsychotics [2] but is also the case for all other psychotropics. Finally, some mental disorders are direct causes of medical complications. That is the case for conditions such as eating disorders, drug abuse or dependence, and the risk-taking behaviours seen in conditions such as conduct disorders and personality disorders in adolescents. The comorbidity between physical and mental illnesses itself causes considerable impairment and unique needs that may complicate routine care.

The view of severe mental disorders, such as schizophrenia, as systemic diseases is not new [4]. In this issue, in an elegant study, Imeraj et al. [3] simultaneously recorded 24-h heart rates and activity patterns in 30 non-medicated children with ADHD and 30 healthy controls over a 5-day period. Heart rate levels in children with ADHD were significantly higher, especially during the afternoon and night-time hours, than in control children after controlling for many confounders. Of course the nature of the study precludes testing if the finding is related to or a consequence of the psychophysiology of the disease.

There is a clear need for effective co-ordination of services involving child psychiatrists and paediatricians [7]. Otherwise children and adolescents with mental disorders are in a poorer position with regard to access to proper medical care. Special health facilities have now been developed in European countries to address these inequalities and to facilitate access to public health care in children and adolescents affected with severe mental disorders [5]. Another important issue is the stigma associated with these disorders, even among medical professionals. The health care system, including paediatricians, should be targeted for programmes aimed at reducing the stigma of mental illness.

As previously mentioned, another source of physical problems in many adolescents with mental disorders is the use

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of nicotine, alcohol and other drugs, which is more widespread than in the general population. In this issue, Riala et al. [6] report that there is not only an association between a diagnosis such as conduct disorder and nicotine dependence among male and female adolescents, but also a correlation between the disease severity, measured as the number of conduct disorder symptoms, and nicotine dependence.

Finally, integrated health-promoting approaches should be developed targeting these populations, tailored to their specific ages and mental diseases.

Paediatricians and family doctors should be educated on the most common comorbid medical conditions that affect children and adolescents with mental disorders. The complexity of the diagnosis, treatment and outcomes of these medical conditions in children with mental disorders should not translate to inferior health care in this already vulnerable population. Programmes that endeavour to minimise the barriers between children and adolescents with mental disorders and the health care system should be explored.

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