

Psychotic symptoms in young people warrant urgent referral

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How do young people present with psychosis?



THE PREVALENCE OF PSYCHOTIC DISORDERS IN CHILDREN AGED BETWEEN 5 AND 18 YEARS

has been estimated to be 0.4%. The symptoms and experience of psychosis and schizophrenia are often distressing and there is a worse prognosis for psychosis and schizophrenia when onset is in childhood or adolescence. However, outcomes are improved with early detection and treatment.

In January 2013 NICE published a guideline which should help improve early diagnosis and optimise treatment of psychosis and schizophrenia in children and young people.¹ About a fifth of children and young people with

How should patients be assessed?

schizophrenia have a good outcome with only mild impairment but a third have severe impairment that needs intensive social and psychiatric support.¹

PRESENTATION

Psychosis is divided into positive and negative symptoms. Positive symptoms include hallucinations and delusions. Negative symptoms include apathy, lack of drive, poverty of speech, social withdrawal and self-neglect.

Psychotic symptoms can be associated with a variety of disorders including schizophrenia, schizoaffective disorder, drug-induced psychosis, personality disorder, epilepsy and autistic spectrum disorder.

What are the treatment options?

The DSM IV criteria for schizophrenia² include two or more of the following:

- Hallucinations
- Delusions
- Disorganised speech
- Grossly disorganised behaviour
- Catatonic behaviour
- Negative symptoms

Thus the presentation of psychosis can vary from a dramatic onset of bizarre behaviour to a gradual onset of social withdrawal and decline in function.

Patients may present independently or be brought to services by concerned adults. Adolescents may present seeking relief from distress or abnormal experiences. Adults may raise concerns >>

SPECIAL REPORT

PSYCHOSIS IN YOUNG PEOPLE

Box 1

Questions that can elicit suspected unusual beliefs or hallucinations

- Have you felt that something odd might be going on that you cannot explain?
- Have you been feeling that people are talking about you, watching you or giving you a hard time for no reason?
- Have you been feeling, seeing or hearing things that others cannot?
- Have you felt especially important in some way, or that you have powers that let you do things which others cannot?

www.iris-initiative.org.uk/silo/files/gp-practice.pdf

about social withdrawal, bizarre ideas, a change in behaviour or a decline in achievement. Psychotic symptoms may be present within the context of a mood disorder and only elicited after sensitive direct questioning.

Psychotic symptoms are much more common than psychotic disorders in the general population.³ This is particularly the case in children. Hearing voices is surprisingly common in prepubertal children, 17% of those aged 9-12 years, falling to 7.5% of adolescents aged 13-18 years. It is important to note therefore that most children and young people with psychotic symptoms will not go on to develop psychosis or schizophrenia. Prepubertal psychosis or schizophrenia is a rare disorder and is likely to present insidiously with a high rate of premorbid psychiatric problems (ADHD, conduct problems and autistic spectrum developmental abnormalities).¹

ASSESSMENT

Discussions should take place in settings in which confidentiality, privacy and dignity are respected.

It is useful to be clear with the patient and their parents or carers about the limits of confidentiality. That is, that you would share information about their illness with other healthcare and social care professionals without their agreement only if there was a significant concern about their safety or that of others.

Sometimes a sympathetic approach asking about the young person's current situation and concerns will reveal symptoms. However, direct enquiry may be needed to elicit suspected unusual beliefs or hallucinations (see box 1, above). To distinguish unusual ideas from delusions the ideas should be tested for fixity. For example, by asking: 'Are you sure? Could there be another explanation?' Mood and anxiety

Box 2

Side effects of antipsychotics

- Metabolic — weight gain and diabetes
- Extrapyrimalidal — akathisia, dyskinesia and dystonia
- Cardiovascular — prolongation of the QT interval
- Hormonal — increased plasma prolactin
- Unpleasant subjective experiences

symptoms should be explored.

The assessment should include a developmental history with particular attention to premorbid functioning. Collateral information from parents/carers (particularly historical information) and from schools will ultimately form an important part of assessment. Failure to make expected progress whether personal, social or academic is significant. Exam results and predicted grades can be a useful guide.

'Better outcomes in terms of symptoms and social function are associated with a shorter duration of untreated psychosis'

A good understanding of any substances the patient has used in the past and is currently using, in particular cannabis and stimulants (amphetamines, cocaine) will enable exploration of their role as a causative or exacerbating factor.⁴

Risks both to the individual and to others as a result of psychotic experiences, or through self-neglect need to be assessed but also placed carefully within the developmental stage of adolescence. So if there are concerns regarding exploitation from others or self-care, they should be assessed according to local safeguarding procedures.

EARLY DIAGNOSIS

The length of time between the onset of symptoms and start of treatment is referred to as the duration of untreated psychosis (DUP), and is estimated as between one and two years in young people.¹ This is longer than that seen in

adults, and gives a greater urgency to improve the detection of psychosis in children. The reasons are likely to be multifactorial: the nature of the early presentation in children being difficult to separate out from other illness, delays in families seeking help in the first place, as well as delays within the health system.

Better outcomes in terms of symptoms and social function are associated with a shorter DUP.⁵ The detection of psychotic symptoms in primary care therefore warrants an urgent referral to secondary care mental health services.

All patients with psychotic symptoms should be referred for assessment and treatment. This should be either to a Child and Adolescent Mental Health (CAMH) team (up to age 17) or a specialist Early Intervention in Psychosis service (age 14 +). These services provide NICE recommended treatment packages for psychosis and schizophrenia — combining medication management, psychological treatments, family work and occupational support for an early return to work or school. Two recent randomised, controlled trials found improved clinical outcomes with this approach⁶⁻⁸ without an increase in cost.^{9,10}

EVIDENCE-BASED TREATMENTS

The treatments recommended by NICE include psychological (CBT and family intervention), physiological (antipsychotics and health monitoring) and practical (vocational and educational support).¹ The evidence base is less well developed in children and young people and the recommendations are largely extrapolated from adult literature.

Psychological therapies

Cognitive behaviour therapy (CBT) is delivered on a one-to-one basis over at least 16 planned sessions. CBT helps patients to establish links between their thoughts, feelings or actions and their current or past symptoms, and/or functioning. CBT can support the re-evaluation of the patient's perceptions, beliefs or reasoning related to the target symptoms. It may include normalising, leading to understanding and acceptance of their experience. NICE recommends CBT for symptom reduction and relapse prevention.

A family intervention is recommended for at least ten sessions over 3 to 12 months. It should have a specific supportive, educational or treatment function. Family interventions can be carried out with a single family or in a group.¹

NICE recommends that arts therapies be considered for children and young people with psychosis or schizophrenia, particularly for the alleviation of negative symptoms.¹

Counselling, supportive psychotherapy, adherence therapy and social skills training have no evidence of benefit.¹

Antipsychotics

Antipsychotics should only be started in young people in secondary care. There is limited evidence of efficacy in children, and a greater rate of side effects. Low

doses should be used. There are no significant differences in efficacy between the antipsychotics.¹ However, there are differences in their side effects (see box 2, p26). Antipsychotics increase weight more than placebo with olanzapine resulting in the greatest weight gain.

The choice of antipsychotic medication should be made by the parents or carers of younger children, or jointly with the young person and their parents or carers, and healthcare professionals.

The patient should be informed that

there is a high risk of relapse if medication is stopped in the one to two year period following the acute episode.¹

Clozapine is recommended as a treatment for children and young people with schizophrenia whose illness has not responded adequately to pharmacological treatment despite the sequential use of adequate doses of at least two different antipsychotic drugs each used for six to eight weeks.¹

Physical health

Various physical investigations are indicated prior to and during antipsychotic drug treatment, see box 3, below.

A small proportion of young people presenting with psychosis will have an identifiable cause for their symptoms, such as encephalitis or thyroid disturbance. Baseline blood tests should therefore also include: FBC; CRP; U&E; TFT; LFT; and ANA. If there is a strong suspicion of organic pathology, for instance if the young person is confused, or the history is of a very rapid deterioration over a few days then an EEG and MRI should also be requested and a neurology opinion sought.

‘There is a high risk of relapse if medication is stopped in the one to two year period following the acute episode’

Unlike the NICE recommendations on schizophrenia in adults, the guideline in younger people recommends that the secondary care team should maintain responsibility for monitoring physical health and the effects of antipsychotic medication for at least the first 12 months or until their condition has stabilised. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements. Commonly, this is with primary care undertaking blood investigations and physiological measures and secondary care monitoring mental state, subjective side effects and adherence.

The guideline recommends that case registers are used and physical health is monitored in primary care at least once a year.¹ The evidence is extrapolated from adults which shows that simple

Box 3

Baseline investigations and monitoring for children and young people who are prescribed antipsychotic medication

	Baseline investigations before starting antipsychotic medication	Monitor weekly for the first six weeks	Monitor at twelve weeks	Monitor every six months thereafter	Monitor regularly throughout treatment, and especially during titration
Weight ¹ (plotted on a growth chart)	✓	✓	✓	✓	
Height ² (plotted on a growth chart)	✓			✓	
Waist and hip circumference (plotted on a percentile chart)	✓			✓	
Pulse	✓		✓	✓	
Blood pressure (plotted on a percentile chart)	✓		✓	✓	
Fasting blood glucose	✓		✓	✓	
HbA _{1c}	✓		✓	✓	
Blood lipid profile	✓		✓	✓	
Prolactin level	✓		✓	✓	
Movement disorders ^{2,3}	✓				✓
Nutritional status, diet and physical activity	✓				✓
The side effects the patient is most or least willing to tolerate	✓				
ECG ⁴	✓				
Efficacy					✓
Side effects					✓
Adherence					✓

¹Calculate and document BMI (percentile).

²Even if no baseline assessment (and at each clinic visit if more frequent).

³Extrapyramidal symptoms, akathisia, dystonia and tardive dyskinesia

⁴If specified in the SPC for adults and/or children; a physical examination has identified specific cardiovascular risk (such as high blood pressure); personal history of cardiovascular disease (CVD); family history of CVD such as sudden cardiac death or prolonged QT interval; or the patient is being admitted as an inpatient.

Adapted from NICE CG155. Psychosis and schizophrenia in children and young people

key points

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There is a worse prognosis for psychosis and schizophrenia when onset is in childhood or adolescence. However, outcomes are improved with early detection and treatment.

Psychotic symptoms can be associated with a variety of disorders including schizophrenia, schizoaffective disorder, drug-induced psychosis, personality disorder, epilepsy and autistic spectrum disorder. Positive symptoms include hallucinations and delusions. Negative symptoms include apathy, lack of drive, poverty of speech, social withdrawal and self-neglect. The DSM IV criteria for schizophrenia include two or more of the following: hallucinations, delusions, disorganised speech, grossly disorganised or catatonic behaviour and negative symptoms. Adults may raise concerns about social withdrawal, bizarre ideas, a change in behaviour or a decline in achievement. Most children and young people with psychotic symptoms will not go on to develop psychosis or schizophrenia.

Direct enquiry may be needed to elicit suspected unusual beliefs or hallucinations. To distinguish unusual ideas from delusions the ideas should be tested for fixity. For example by asking: 'Are you sure? Could there be another explanation?' Mood and anxiety symptoms should be explored. The assessment should include a developmental history with particular attention to premorbid functioning. Failure to make expected progress whether personal, social or academic is significant. The differential diagnosis may include anxiety and depressive disorders.

Better outcomes in terms of symptoms and social function are associated with a shorter duration of untreated psychosis. The detection of psychotic symptoms in primary care therefore warrants an urgent referral to secondary care mental health services for assessment and treatment.

The treatments recommended by NICE include psychological (CBT and family intervention), physiological (antipsychotics and health monitoring) and practical (vocational and educational support). Antipsychotics should only be started in young people in secondary care. There is limited evidence of efficacy in children, and a greater rate of side effects. Low doses should be used. The patient should be informed that there is a high risk of relapse if medication is stopped in the one to two year period following the acute episode.

NICE recommends that the secondary care team should maintain responsibility for monitoring physical health and the effects of antipsychotic medication for at least the first 12 months or until the young person's condition has stabilised. Thereafter, the responsibility may be transferred to primary care under shared care arrangements.

interventions might have some impact on the lifestyle factors associated with increased morbidity, for example group interventions for smoking cessation in patients with schizophrenia.¹¹

Vocational support

The NICE guideline recommends educational liaison and vocational support.¹ One randomised controlled trial in young people with a first episode of psychosis has shown a benefit of individualised vocational support compared with treatment as usual in finding employment.¹²

Treatment for transient or attenuated psychotic symptoms

Young people with either transient or attenuated psychotic symptoms are considered as having an 'at risk mental state' with increased risk of developing a future psychotic illness, although current evidence is that fewer than 10% of these patients will develop a full syndrome of psychosis over two years.¹³

However, the psychotic symptoms may still be associated with distress and warrant treatment in their own right. CBT with or without family therapy is recommended to reduce the severity and intensity of the experiences.¹³

It might also be appropriate to offer other NICE recommended treatments for any co-existing anxiety disorder, depression, emerging personality disorder or substance use.¹ It is not appropriate to offer antipsychotic treatment.¹ The risks associated with cannabis should be explained.⁴

CONCLUSION

GPs should suspect psychosis in children and young people who fail to make expected progress or those who withdraw socially as well as those presenting with more obvious hallucinations and delusions.

The differential diagnosis may include anxiety and depressive disorders. A rapid referral to a CAMH or an Early Intervention for Psychosis service should be made. Evidence-based treatments include family intervention and individual CBT combined with antipsychotic treatment.

Vocational support and educational liaison is recommended. Physical health assessment is important both to exclude general medical causes and to monitor the effects of antipsychotics.

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Useful information

NICE CG155. Psychosis and schizophrenia in children and young people

Versions for healthcare professionals and patients, parents and carers are available from www.nice.org.uk

For patients and carers

www.rethink.org

www.emental-health.com

www.sane.org.uk

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