Transition from Children and Adolescent Mental Health Service (CAMHS) to Adult Mental Health Service (AMHS): are the patient referrals appropriate for Early Intervention Psychosis Team?

Dr Mengfei Lu[1], Dr Louise Guest[1]
1 South West London and St George's Mental Health NHS Trust, UK

South West London and St George's Mental Health NHS Trust

Background

Merton Early Intervention Psychosis (EIS) team assesses patients between 17-65 years old who present with first episode of psychosis. The current trust policy states that 'whilst psychotic patients with secondary drug abuse or co-morbid personality disorders are suitable for the service, those with a primary diagnosis of personality disorder and/or transient substance-induced psychosis will not be considered appropriate' (1). Young patients typically present with first-rank symptom of auditory hallucination as their initial symptom. However, studies have shown that auditory hallucinations are comparatively common in childhood and adolescence, it has been suggested that auditory hallucinations can present similarly in borderline personality disorders and autism spectrum disorder (ASD) (2, 3). Maijer K et al, 2019, proposed that anti-psychotics should not be the first-line treatment of non-psychotic hallucinations (2). A holistic perspective has been recommended before considering pharmacological intervention (2, 4).

Methods

Between May 2017 and November 2019, 12 patients have been referred to Merton EIS for transitional care support by local CAMHS team. All clinical data are collected retrospectively. The data is reviewed systematically on RIO system, anonymised and tabulated into Microsoft Excel.

Aims and objectives

1. To assess the referrals to Merton EIS for transitional care from CAMHS and review their diagnosis, medications and outcome.
2. To create a better strategy to identify suitable patients for EIS team.
3. To improve patient experience and clinical outcome by effectively directing CAMHS patients to the appropriate AMHS.

Table 1 Clinical summary of 12 patients referred to Merton EIS between May 2017 and November 2019

Patient	Diagnosis	Medications	Psychology	Current status	Initial Presentation	Background	Possible ASD
1	Dissociative disorder	Sertraline 100mg OD	Declined	Discharged	Auditory and visual hallucination, thought disorder	Eating disorder, anxiety, depression, overdose	Yes
2	Unspecified non-organic psychosis	Risperidone 2mg ON, Aripiprazole 5mg OM	Not necessary	Transferred to other EIS due to University	Thought disordered, social withdrawal and change in character		Yes
3	Unspecified non-organic psychosis	Risperidone 2mg ON	Not offered	Transferred to other EIS due to University	Thought disordered, persecutory delusions, spiritual belief and behaviour out of character		
4	Emotionally unstable personality disorder	Quetiapine 75 mg ON (for sleep)	Improvements	Discharged	Anxiety, depression, insomnia, suicidal ideation and auditory hallucination	Eating disorder	Yes
5	Emotionally Unstable Personality Disorder	None	Improvements	Discharged	Visual hallucination, BG: suicidal ideation, anxiety and depression	Obsessive-Compulsive Disorder	Yes
6	Conduct Disorder	None	Improvements	Discharged upon first medical assessment	Auditory and visual hallucination and paranoia	Conduct disorder, learning difficulties, anxiety, illicit drug use	Yes
7	Antisocial Borderline Personality Disorder Drug-induced Psychosis Conduct Disorder	Olanzapine 7.5mg ON	Improvements	Pending Discharge	Auditory hallucination and paranoia, delusional beliefs	Violence, suicidal ideation, delayed speech and language, ADHD, forensic history, Polysubstance Misuse	
8	Emotionally unstable personality disorder	None	Improvements	Discharged upon first medical assessment	Auditory hallucination, paranoid ideation ?secondary to cannabis	Anxiety, behavioural difficulties, childhood abuse and neglect	
9	Conduct Disorder Emotionally unstable personality disorder	Aripiprazole 10mg OD (ineffective)	Improvements	Referral not accepted after MDT discussion	Auditory and visual hallucination	Self-harm, overdose, ADHD, substance misuse	
10	Schizoaffective Disorder	Olanzapine 10mg BD, Quetiapine 75mg ON, Zopiclone 7.5mg ON, Atomoxetine 20mg + 80mg	Improvements	Discharged due to out of borough	Auditory hallucination and paranoia	ADHD, moderate learning difficulties, overdose	Yes
11	Dissociative disorder, moderate depressive disorder	Sertraline 150mg OD	Declined	Discharged	Auditory and visual hallucinations, paranoia	Depression and anxiety	
12	Ongoing assessment - ?ASD, stress related reaction	Promethazine 25mg ON PRN	Improvements	Ongoing assessment	Auditory hallucination, suicidal ideation		Yes

Results

10/12 (83.3%) of the patients presented with either or both auditory and visual hallucinations. Only 2/12 (16.7%) of the patients have the confirmed diagnosis of unspecified non-organic psychosis with ongoing EIS support, and neither patient had initial presentation of hallucination. 1 patient has a query diagnosis of schizoaffective disorder at the time of referral but was unable to be followed up as the patient moved out of borough. 1 patient has a complex psychiatric history with drug-induced psychosis.1 patient is currently still under EIS for extended assessment for query ASD and stress-related reaction. 7/12 (58.3%) of the patients has had querying diagnosis of ASD.

Discussion and Conclusion

Neither of the patients with the diagnosis of unspecific non-organic psychosis presented with auditory or visual hallucinations initially. Both of them responded well to anti-psychotics and have had positive outcomes. Both patients presented initial psychotic symptoms at the age of 18, and neither is previously known to CAMHS. Patients that are known to CAMHS from an earlier age are more likely to have diagnosis of EUPD, dissociative disorder and conduct disorder. These patients typically have a complex background of learning difficulties, ASD, ADHD and eating disorders. Most of these patients do not remain on anti-psychotics, and experienced greater benefits from psychotherapy.

Auditory and visual hallucinations are not reliable indicators to assess the nature of psychosis in children and adolescence. Large proportions of patients that are referred to Merton EIS from CAMHS do not have true clinical diagnosis of non-organic psychosis, and were consequently discharged to other community teams in which disrupts the continuity of care and delays treatment plans. Prompt initial medical assessment prior to accepting the referral facilitates the smooth transfer of these patients' care to other relevant mental health teams if they do not fit into the EIS criteria.

Reference

Early Intervention Services Operational Policy. South West London and St George's Mental Health NHS Trust. May 2018.

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