Study No | | | | CAPSS No. | | |

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CHILD & ADOLESCENT PSYCHIATRY SURVEILLANCE SYSTEM

Questionnaire

STRICTLY CONFIDENTIAL

Surveillance of Childhood-Onset Non-Affective Psychosis in the UK and ROI

Surveillance Case Definition

Any child under 14 in the UK and ROI meeting the criteria for an initial episode of Schizophrenia or related psychoses (as defined by ICD-10) characterised by at least **one** of the following: persistent delusions; hallucinatory voices giving a running commentary or discussing the young person, or voices coming from a body part; thought echo, insertion, withdrawal or broadcasting AND/OR **two** of the following: hallucinations in any modality, when occurring every day for at least one month, when accompanied by delusions or over-valued ideas; formal thought disorder; catatonic behaviour; "Negative" symptoms.

These symptoms/behaviours should have been present (at least briefly) on most days for at least one month.

This page will be detached and stored separately from the rest of the questionnaire to ensure that patient identifiable information is unlinked to the clinical data. This page will be destroyed once de-duplication is confirmed and follow-up questionnaires have been issued. (This study has been approved by West London REC 2 *(10\H0711\32) and has been granted NIGB Section 251 support to process patient identifiable information without consent).*

For further information or queries, please contact: Dr Paul Tiffin

Please return completed form in the pre-paid envelope to: **Dr Paul Tiffin**
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General Information

Person completing questionnaire (BLOCK CAPITALS please): ……………………..……………….……..

Hospital or CAMH Service: …………………………………………………………………….……………………..

Consultant responsible for reported case: ………………………..………………………………………….

Contact telephone number: …………………….…………………………………………………………….

Contact email: ………………………..……………………………………………………………..………..

Patient details:

NHS/ CHI/ H&C Number (if applicable): ……..…………………….……

Date of Birth (dd/mm/yy): [ ][ ] / [ ][ ] / [ ][ ]

Gender (please circle): Male / Female

Post-code (first part and second part digit only, e.g. CA11 2, HP5 3 etc): [ ][ ][ ][ ][ ]

Date first seen by you with psychotic symptoms: [ ][ ] / [ ][ ] / [ ][ ]

Date today: [ ][ ] / [ ][ ] / [ ][ ]

Duration of Psychotic symptoms (weeks): [ ][ ][ ]

Patient ethnicity (please tick):

WHITE:
- ☐ British
- ☐ Irish
- ☐ Other (describe below)

BLACK:
- ☐ African
- ☐ Caribbean
- ☐ Other (describe below)

MIXED:
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Other (describe below)

ASIAN:
- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Other (describe below)

CHINESE:
- ☐ Chinese

OTHER:
- ☐ Other (describe below)

If "OTHER", please describe: ……………………………………………………………………………………………

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Presenting Psychotic Symptoms

1. Please indicate the presenting psychotic symptoms by ticking the appropriate box and providing a brief description:

Symptom	Yes	No	Describe briefly
Hallucinations and other perceptual disturbance?			
Delusions and other ideational disturbance (include delusional mood and overvalued ideas)?			
Formal Thought Disorder or other disturbances in the flow of thinking?			
Incongruous Mood			
"Negative" symptoms (marked withdrawal, poor motivation, blunted mood, paucity of thought)?			
Catatonia (mutism, posturing, waxy flexibility, alternating over - and underactivity)?			
Other psychotic symptoms (e.g. thought broadcasting, passivity phenomena)?			

Non-Psychotic Symptoms

2. Please indicate which of the following features have been reported in this child in the course of this episode of psychosis.

Symptom	Yes	No	Describe briefly
Elevated Mood (e.g. elation, irritability)?			
Depressed Mood (e.g. sadness, anhedonia, tearfulness)?			
Anxiety (e.g. generalised, phobic, social anxiety)?			
Changes to Sleep and Appetite?			
Obsessions/Compulsions?			
Conduct Problems/Disturbed Behaviour (e.g. disinhibition)?			

3. Evidence of risk (please circle):

a) Self-Harm:	HIGH	MODERATE	LOW
b) Aggression/Violence:	HIGH	MODERATE	LOW
c) Contact with Police:	YES	NO	

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Comorbidity

4. Does the child have a history of any of the following mental health/developmental disorders?

	YES/Probable	NO
Anxiety Disorder	☐	☐
Attention Deficit Hyperactivity Disorder or problems with attention control	☐	☐

	YES//Probable	NO
Autism Spectrum Disorder (include mild/atypical presentations)	☐	☐
Conduct or Oppositional Defiant Disorder	☐	☐
Depressive Disorder	☐	☐
Substance Use Disorders (if yes, please specify below)	☐	☐

Substances used:……………………...………………………………………………………………………………

	YES/Probable	NO
Other Mental Health/Developmental Comorbidity	☐	☐

If YES, please specify: ……………………………………………………………………………………………………

	YES	NO
5. Current/previously <u>prescribed stimulants</u>?	☐	☐

If YES, details of prescribed stimulants (if known): …..………………………………………………………………………

6. Has the patient had a medical disorder in the past year requiring in-patient/out-patient treatment?

YES	NO
☐	☐

If YES, please specify: ………………..……………………………………………………………………………………

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Family History Details

7. Is there any family history of psychiatric disorder? Yes/Probable ☐ No ☐

If YES/Probable, please tick relevant box(es) below and specify relationship to child (e.g. maternal grandfather, half-brother)

RELATIONSHIP TO CHILD

Schizophrenia or related disorder*	☐	--
Transient Psychosis**	☐	--
Bipolar Disorder (I or II)	☐	--
Unipolar Depression	☐	--
Any anxiety disorder	☐	--
Substance use disorder	☐	--
Attention Deficit Hyperactivity Disorder	☐	--
Autism Spectrum Disorder	☐	--
Other	☐	--

Please give relevant details:

……

……

* Include probable Schizotypal Disorder

** Include brief psychosis (<7days) in response to stress or substance use

Impact of Illness on Functioning

8. Level of premorbid functioning (prior to onset of frank psychosis)

	Good	Moderate	Poor
Educational:	☐	☐	☐
Social:	☐	☐	☐
Self-care/ practical:	☐	☐	☐

9. Level of current functioning

	Good	Moderate	Poor
Educational:	☐	☐	☐
Social:	☐	☐	☐
Self-care/ practical:	☐	☐	☐

10. IMPACT on FAMILY (functioning, distress etc):

☐ **Mild** ☐ **Moderate** ☐ **Severe**

Any other relevant details relating to impact of psychotic illness on functioning?:

……

……

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Management

11. Has the child required admission to day/inpatient psychiatric service? (Tick all relevant boxes)

Psychiatric Inpatient (secure) ☐ Psychiatric Inpatient (open ward) ☐ Day patient ☐
Paediatric admission ☐ Outpatient only ☐

12. If the child was admitted, was mental health legislation used during admission?
Yes ☐ No ☐

If YES, please specify (e.g. admitted under Mental Health Act sec 2):
……………………………………………………

13. Please tick any medication(s) currently prescribed and specify dose (if known)

		Dosage	Not Known
Risperidone	☐	______________________	☐
Quetiapine	☐	______________________	☐
Olanzapine	☐	______________________	☐
Other antipsychotic	☐	______________________	☐

If "Other", please specify: ………………………………………………………...

Other psychotropics	☐	______________________	☐

Please specify, if applicable: ………………………………………………………….

14. Has Psychosocial Intervention been offered/used (e.g. family work)? Yes ☐ No ☐

If YES, please specify: ……………………………………………………………………………………

……

15. Any other CAMHS professional or agency involvement? Yes ☐ No ☐

If YES, please specify:……………………………………………………………………………………...

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MANY THANKS FOR YOUR HELP.

Please return this questionnaire using the SAE provided