At Risk Mental State – but at risk of what?
An opportunity for discussion

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• ARMS
• UHR subgroups & transition rates
• Diagnoses in those with ARMS
• ‘Non-converters’
• What we’re doing in NZ EI teams
• Comments from EI teams
• Chance to discuss
ARMS by other names

- UHR
- PLE
- CHR
- Early Initial Prodrome state
- Basic Sx
- Prodrome (but only retrospectively)
Goals of Intervention for ARMS

- Reduce risk of transition to psychosis
- Delay transition to psychosis
- Reduction in symptoms, distress, and disability
- Treatment of co-morbidity
- Prevention/minimization of neurobiological change
- Reduction of DUP in case of transition
- Increase acceptance of treatments
- Effective early treatment avoids hospitalization/limits damage
- Engage while social function and networks intact
- Assist in research
- Development of therapeutic relationship
- Maintenance of function/or early rehabilitation
ASSESSMENT TOOLS

KEEP CALM AND USE SIPS
ASSESSMENT TOOLS

• CAARMS - Comprehensive Assessment of At Risk Mental State (Abbreviated vs full)
• SIPS
• PQ-16
UHR groups

- Attenuated Psychosis group
- BLIPS group
- Vulnerability group
Attenuated psychotic Sx

• May reflect the emergence of an underlying core psychotic process
• some may be “clinical noise” associated with a nonpsychotic clinical condition
• some may be normal variations among the general population.
• Attenuated symptoms such as perceptual abnormalities may not necessarily reflect the emergence of a core psychotic process

Nelson et al 2013
Level of risk in subgroups

• Meta-analysis of psychosis risk over 24 months:
  85% APS, 10% BLIPS, 5% GRD
• BLIPS highest transition rate
• Query validity of GRD subgroup

Fusar-Poli et al 2016
"PACE 400"

- 416 subjects followed 10+ yrs

<table>
<thead>
<tr>
<th>Time (yr)</th>
<th>Transition Rate (%)</th>
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<tbody>
<tr>
<td>1</td>
<td>16.5</td>
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<tr>
<td>2</td>
<td>20.4</td>
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<tr>
<td>5</td>
<td>30.1</td>
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<tr>
<td>10</td>
<td>34.9</td>
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Yearly transition risk from ARMS to psychotic disorder

- 0.2% diagnosed with a psychotic disorder
- 14-25% with attenuated psychotic experiences
- 0.6% Help seeking ARMS individuals
- 22% diagnosed with a psychotic disorder

General population

(Fusar-Poli et al 2013)
Outcomes for Non converters

- At follow-up 28% reported attenuated psychotic symptoms
- Over follow-up period 68% had NPDs
- 51.65% had a persistent or recurrent disorder
- Disorders persisted for approx. half of the young people who did not develop psychosis.

Lin et al 2015
Neurocognitive predictors

• 41 of 230 UHR clients – poorest outcome

• Only 48.8% had transitioned to psychosis

• Strong association

• Risk for psychosis vs risk of poor functioning

Lin et al 2011
Diagnoses among help seeking individuals with an At Risk Mental State

(Woods et al 2009, Fusar-Poli et al 2012)
Related Info

- 2009 study 21% of those with ARMS had been prescribed antipsychotics by the referrer (McGorry and Nieman)
- Canadian ADAPT study (2011) comparing CBT to supportive therapy in CHR
- Preti & Cella’s 2010 review of RCTs
“The HR state should therefore not be considered as the prodromal state of schizophrenia. Instead it should be seen as heterogeneous, capturing some individuals with an admixture of affective and psychotic symptoms and some with a true vulnerability to schizophrenia”

Fusar-Poli et al 2014
And in NZ?
Formal process
Assessment tools
Working with ARMS clients

• Time: Between 6-12 months ( ? 1 X up to 3 years).

What’s offered:

• targeting symptoms
• identifying issues (employment, substance use)
• psychoeducation / coping strategies
• Psychology, OT, work with families.
• Omega-3 Fatty Acids
Data
30 clients
Accepted for extended assessment over the last 4 years
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50% turned out to have ongoing psychosis or bipolar with psychosis and went on to receive EIS support and treatment for at least 2 years

50% did not show evidence of a psychotic disorder after extensive observation and assessment
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50% did not show evidence of a psychotic disorder after extensive observation and assessment

Diagnoses on discharge include:

- OCD
- Anxiety disorders
- Social phobia
- Polysubstance abuse
- Severe depressive disorder
- Bipolar single episode in remission
What’s been learnt

• Interesting and rewarding work.
• It was great helping people make sense of their anomalous experiences.
• Opportunity to normalise and ‘undiagnose’ psychosis.
• Hard to determine whom you have prevented from transitioning through the interventions.
• A difficult group to engage, and the risks could be very high.
• If clients reduce or stop their substance use frequently their sx disappear or at the very least become less distressing or problematic.
Other comments / observations

- Working with ARMS clients can mean shorter DUP/ smoother transition to treatment
- If working within EI teams, need clear guidelines
- Need for appropriate funding & training a difficult group to engage, and the risks could be very high.
• “Should take a normalising non-catastrophic perspective on their psychotic experiences and any treatment should largely be needs driven....active monitoring may also be beneficial and would be benign and easy to implement”

Morrison et al 2012
A chance to discuss
Questions for us all

• (i) What is your DHB planning in terms of addressing At Risk Mental State?

• (ii) What are the key things you think should be considered in any such plans?
What’s next......