Identifying transition to First Episode Psychosis from 'At Risk Mental State' in Sussex Early Intervention in Psychosis services

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INTRODUCTION

Identification of a psychosis risk syndrome to aid reduction of transition to a First Episode Psychosis (FEP) is an important focus of worldwide research.[1,2] At Risk Mental State (ARMS) for psychosis was defined by Yung and McGorry in 1996.[3]

UK Early Intervention in Psychosis (EIP) services were mandated to identify and 'treat' ARMS in the 'Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance' 2016.[4]

Sussex EIP services developed such an ARMS service with a 1-year pathway of assessment, intervention as indicated, and monitoring from 2017. Sussex serves a population of approximately 1.4 million, including areas with both low and high social deprivation indices.

Transition rates from ARMS to FEP in recent studies have suggested widely varying rates, most commonly around 8-17% of transition in a two-year period, notably less than initially identified by Yung et al.[5,3]

AIM

We aimed to establish the rate of transition to FEP within 12 months from identification of ARMS in Sussex EIP services.

METHOD

A retrospective study was conducted on all patients on the ARMS pathway, across five EIP services in Sussex, between Jan 2017-Oct 2021.

The primary outcome measure was operationally defined transition to FEP, using the PANSS scale of 4 or more on delusions or hallucinations items, or 5 or more on conceptual disorganisation for 7 days or more. Secondary outcome measures included clinical features and use of clinical services.
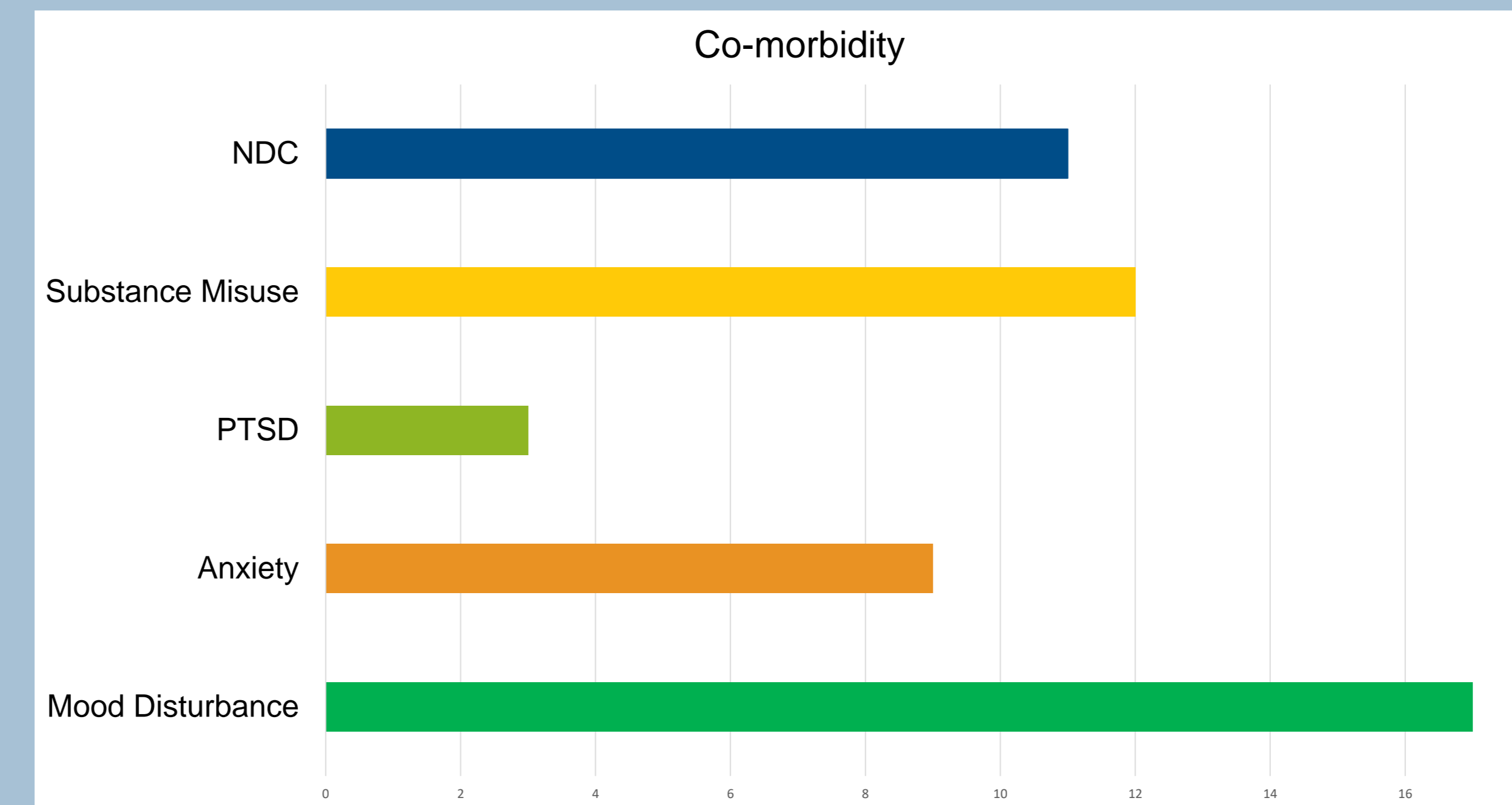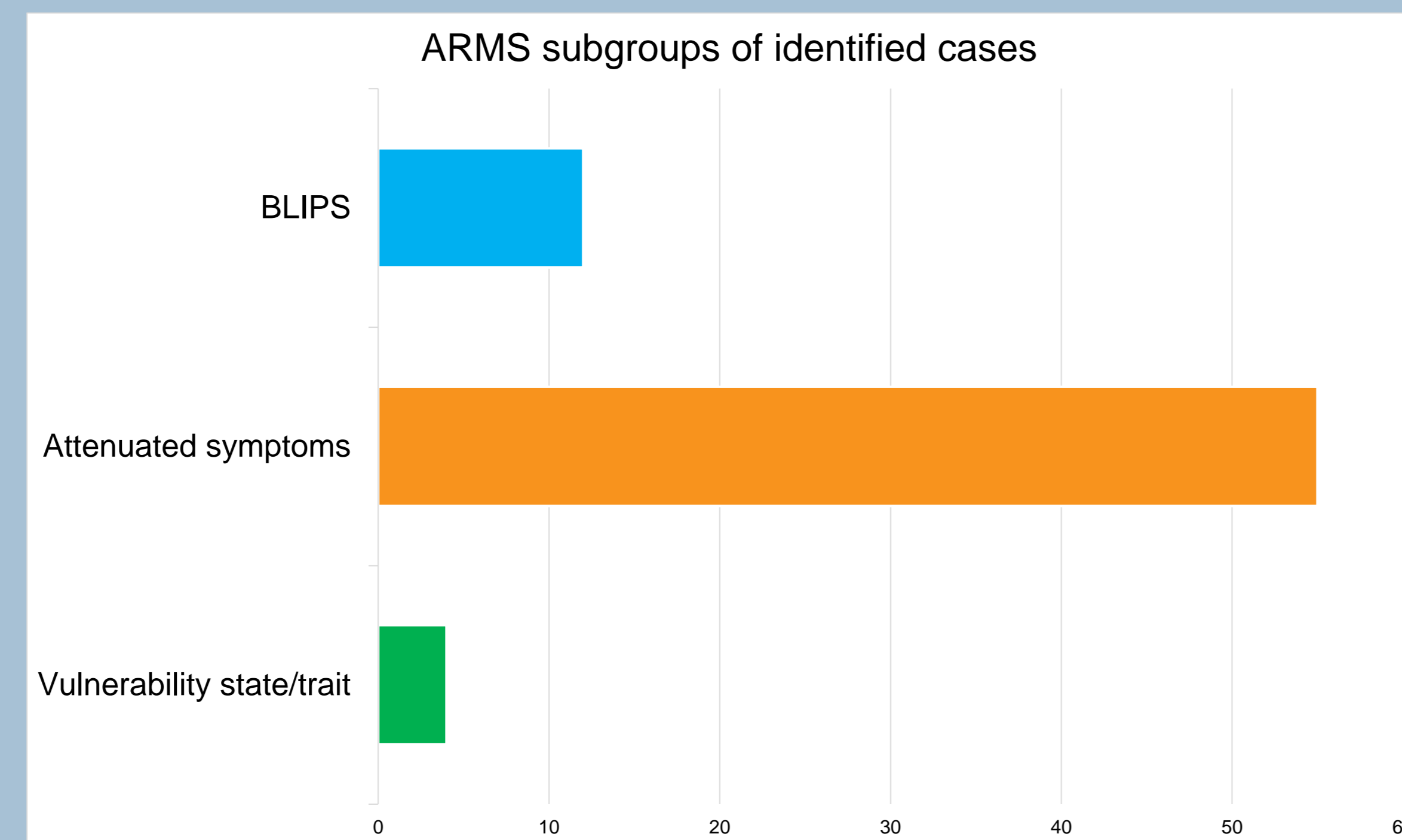
RESULTS

71 cases were identified as meeting ARMS criteria from a total caseload of 447 over this time period.

Mean age 21.4yo; range 14-35; 16 cases were under 18.

Progressively less identified each year 25 in 2017, 16, 15, 12, 1 in 2021.

We identified the following **ARMS subcategories**: 4 state/trait, 55 attenuated psychosis and 12 BLIPS.

ARMS subgroups of identified cases

Co-morbidity

Co-morbidity was more common than not, including mood disturbances (17), anxiety (9), PTSD (3), substance misuse (12), and neurodevelopmental conditions ADHD/ASC (11).

All cases received full care coordination by lead practitioners.

In terms of medications, 19 cases were prescribed atypical antipsychotics; 26 antidepressants; 11 other medication including benzodiazepines/hypnotics.
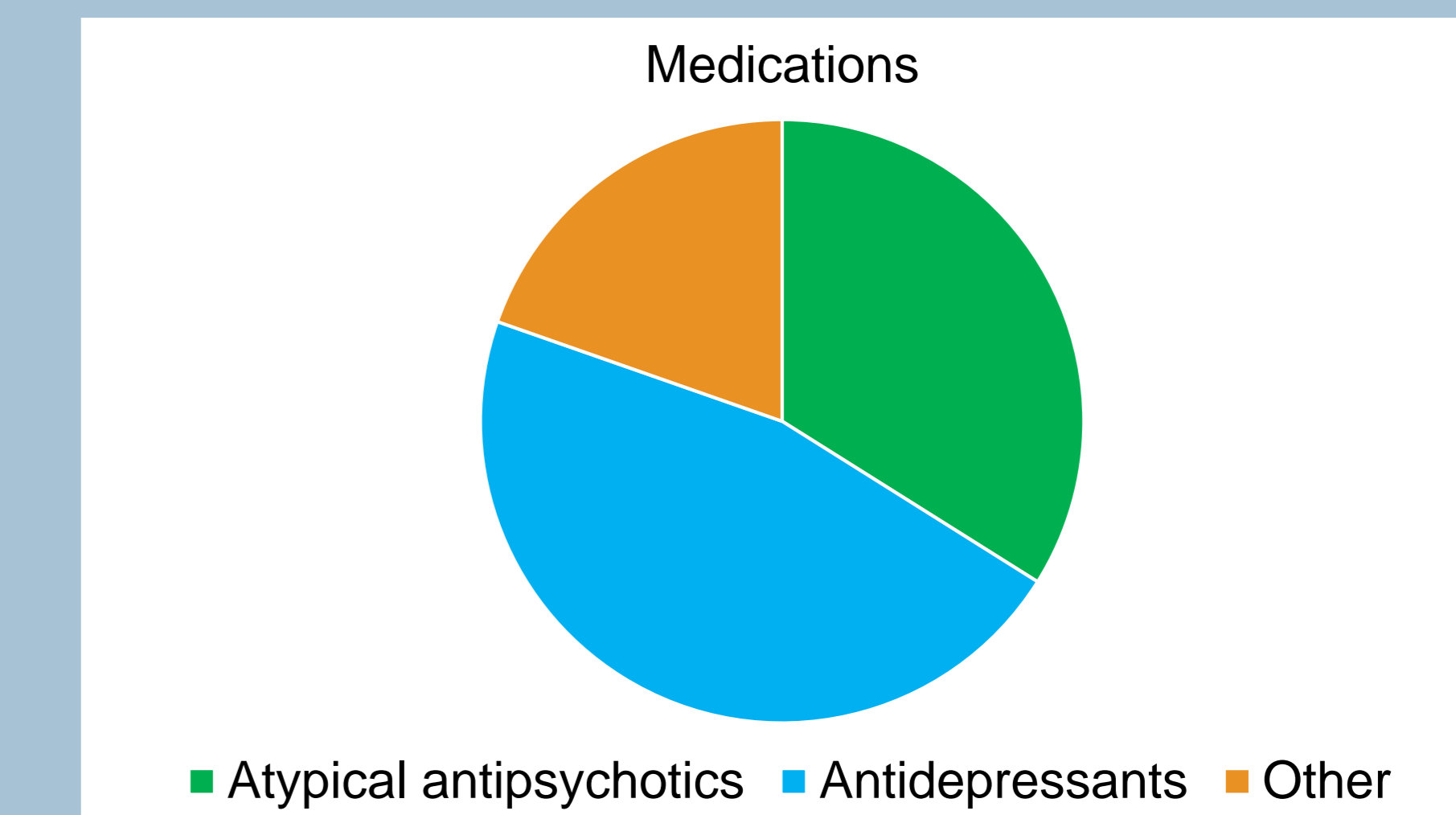
18 cases received formal CBT. Further intervention included family intervention (3), vocational support (10), STR (4), recovery-oriented groups (2).

Of note, 23 were not in education or employment (NEET), whilst 28 were studying (school/university) and 20 were working or in employment.

4 of 71 cases **transitioned** to FEP within 12 months (6%), within 12 months at mean time 35 weeks; range 28-45 weeks.

2 had attenuated symptoms and 2 experienced BLIPS. 3 were initially NEET.

Statistics weren't attempted due to low number of transitions, but kept to a descriptive account.

Medications

CONCLUSIONS

We have identified a relatively low transition rate of **6%**, consistent with recent national studies and as previously identified in this service (8%; Harpwood et al.)

Risk saturation is arguably required to justify continuing this ARMS pathway, with a focus on BLIPS subgroup.

Wider review of UK ARMS services is required to reduce dilution of EIP service models and reduction of their well evidenced effectiveness.

Limitations of this service audit include manual extrapolation of data using available clinical documentation but it clearly reflects what has happened in recent years.

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