

Clinical High Risk for Psychosis (CHR-P) Stepped Care

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SAMHSA
Substance Abuse and Mental Health
Services Administration

Housekeeping Notes

- This presentation will be recorded.
- You will receive a link to the presentation slides and recording via email.
- During the presentation, submit questions and comments in the chat.



Webinar Overview

- I. Opening Remarks
- II. Overview of Clinical High Risk for Psychosis (CHR-P) Stepped Care
- III. Panel Discussion
- IV. Q&A
- V. Closing Remarks



ESMI TTA CENTER

SAMHSA's National Training and Technical
Assistance Center for Early Serious Mental Illness

Learning Objectives

- Describe the concept of stepped care in the context of CHR-P programs
- Identify three points during the therapeutic process when assessment of treatment response is recommended
- Identify at least three objective measures for determining treatment response





Introduction

Nicholas Breitborde, PhD

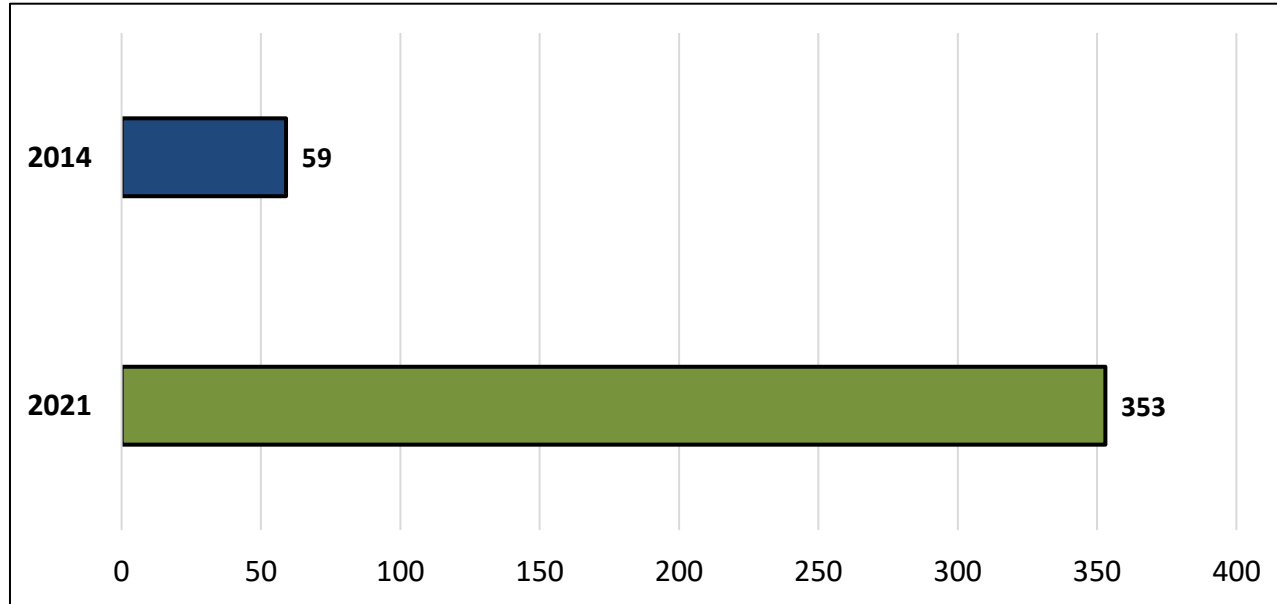
Professor and Director, Early Psychosis Intervention Center (EPICENTER)

The Ohio State University

Progression of Schizophrenia

- **Premorbid phase**
 - Decreased cognitive, motor, or social abilities
- **Prodromal phase**
 - Brief experience of subthreshold symptoms of psychosis symptoms and/or diminishing functional abilities
- **Psychotic phase**
 - Onset of psychotic symptoms
- **Stable phase**
 - Experience of negative symptoms, cognitive and social difficulties, and decreased functional abilities

National Expansion of Coordinated Specialty Care



Early Intervention for Psychosis

- Symptoms begin developing during the prodromal phase of schizophrenia
- Intervention typically commences only after the first onset of psychotic symptoms
- Targeted early intervention at the prodromal phase could prevent or delay the onset of a psychotic disorder

The “Prodromal” Patient: Both Symptomatic and At-Risk

By Scott W. Woods, MD, Tandy J. Miller, PhD, and Thomas H. McGlashan, MD

ABSTRACT

This article discusses conceptual issues relevant to the prospective diagnosis of the schizophrenic prodrome. Recent efforts to diagnose these patients with operational criteria based on current symptoms are reviewed. Symptomatic patients so identified appear to be treatment-seeking and to have mild cognitive impairments. In addition to being currently symptomatic, these patients are imminently at risk for progression of illness and development of schizophrenia. Data from three international centers suggest that this risk is approximately 40% over the next year of follow-up if untreated. The implications of the reviewed data for the appropriateness of the term “prodromal” and for treatment/prevention research for these patients are discussed.

CNS Spectrums 2001;6(3):223-232

than haloperidol, which has usually been used as the active comparator agent in studies. Two studies^{28,29} suggest that the long-term risk of tardive dyskinesia (TD) may be lower for the atypical agents as well.

Fourth, recent developments suggest that a prodromal state may be identified based on current symptoms with reliability and predictive validity for the risk of development of schizophrenic psychosis in the following year. This evidence will be reviewed in detail later.

Fifth, as researchers and clinicians have begun to identify prodromal patients and gain clinical experience with them, appreciation is growing that these patients and their families experience substantial current distress. Thus, current symptoms provide another rationale for intervention research in addition to the need for research targeting the prevention of schizophrenia.

Nuances in Treatment for Individuals at Clinical High Risk for Psychosis

TABLE I. *International guidelines' recommendations on AP prescription in CHR-P.*

	Year	First Line Treatment	AP-Medication
NICE	2016	CBT	Do not offer AP medication
EPA	2015	CBT	Use low-dose second-generation AP if psychological treatment has proved ineffective or CHR-P symptoms get worse
ACG	2016	CBT	AP only if there's evidence of at least 1 week of frank positive psychotic symptoms, or if positive symptoms are milder or briefer, but are directly associated with risk of self-harm or aggression
CTG	2017	Individual CBT with or without family intervention; Treat comorbid disorders	Use low-dose second-generation AP for short-term period only if previous psychological interventions have proven ineffective
ISS	2007	CBT	Do not offer AP medication
ER Recommendation	2023	CBT	AP only if functional impairment, a high risk of self-healing, and ineffectiveness of first-line psychosocial interventions

Legend - NICE: National Institute for Health and Care Excellence; EPA: European Psychiatry Association; ACG: Australian Clinical Guideline; CTG: Canadian Treatment Guidelines; ISS: Istituto Superiore di Sanità. ER: Emilia-Romagna region.

**Department of Health and Human Services
Substance Abuse and Mental Health Services
Administration**

**Community Programs for Outreach and Intervention with
Youth and Young Adults at Clinical High Risk for Psychosis**

(Short Title: CHR-P)

(Initial Announcement)



Funding Opportunity Announcement (FOA) No. SM-18-012

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243

Stepped Care for Individuals at Clinical High Risk for Psychosis

- Begin with low intensity, evidence-based treatments
- Assess response to treatment
- Individuals not responding to initial treatments advance to move intensive treatments until response is achieved

Stepped Care Model Example—EPICENTER v1

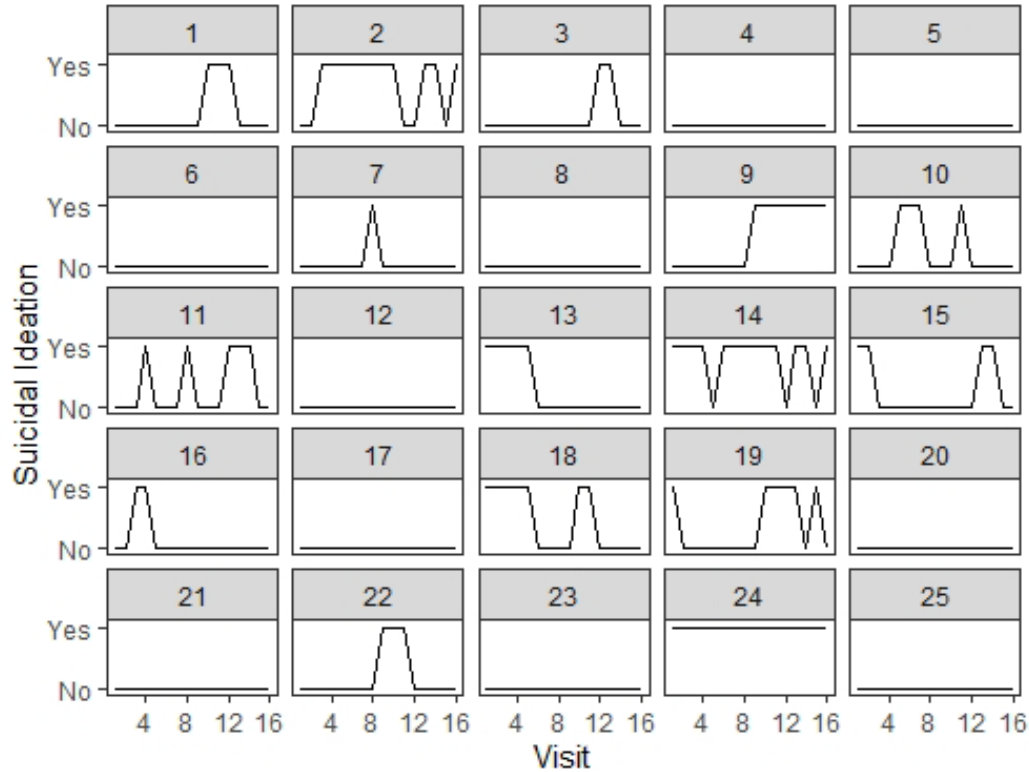
	Intervention track				
Intensity/ specificity to CHR-P	Psychotherapy	Pharmacology	Family support	Peer support	Vocational and educational support
Lower   Higher	<ul style="list-style-type: none"> • Psychoeducation • Substance use reduction 	—	Clinic orientation	Social skills group	Offered at all levels
	<ul style="list-style-type: none"> • Unified protocol 	Consider nonantipsychotic medication	Joining sessions		
	<ul style="list-style-type: none"> • CBT_{CHR-P} • MCR 	Consider antipsychotic medication	Multi-family group		

Assessing Response to Treatment

- Symptomatic Response
 - Structured Interview for Psychosis-Risk Syndromes (SIPS)
 - Mini-SIPS
- Functional Response
 - Personal and Social Performance Scale (PSP)
 - Social and Occupational Functioning Assessment Scale (SOFAS)
- Other Mental Health Concerns
 - Suicidality (e.g., Columbia Suicide Severity Rating Scale [C-SSRS] Self-Report)
 - Depressed Mood (e.g., Patient Health Questionnaire [PHQ-9])
 - Anxiety (e.g., Generalized Anxiety Disorder [GAD-7])

The Need for Frequent Assessment

Figure 1. Variability in suicidal ideation across 16 sessions of individual psychotherapy for individuals at CHR-P.



Initial Cohort of SAMHSA-Funded CHR-P Programs

- SAMHSA funded 21 programs in the first cohort to deliver stepped care for individuals at CHR-P
- Initial cohort locations
 - Oregon, California, Utah, New Mexico, Illinois, Tennessee, Kentucky, South Carolina, Ohio, Pennsylvania, Maryland, Delaware, New Jersey, Connecticut
- SAMHSA has since awarded a second cohort to expand access to CHR-P programs

Stepped Care Preliminary Outcomes


- 67% achieved symptomatic response
 - Median time to response = 11.1 weeks
- 64% achieved functional response
 - Median time to response = 8.9 weeks
- Majority of individuals meeting symptomatic or functional response were not on antipsychotic medication



Questions Moving Forward

- Optimizing treatment options?
- Engagement and retention strategies?
- Discharge planning?
- Context/locations of CHR-P programs?

Stepped Care Model Example—EPICENTER v2

	Psychotherapy	Pharmacology	Family Support	Peer Support	Vocational & Educational Support
 <p>Lower Intensity</p> <p>Higher Intensity</p>	BEGIN Psychoeducation	Consider Non-Antipsychotic Medication	Clinic Orientation	Peer Support Group	Supported Employment and Education Services
	Unified Protocol		Joining Session		
	CBT _{CHR} MCR	Consider Antipsychotic Medication	Multi-Family Group	Social Skills Group	

Questions Moving Forward

- Optimizing treatment options?
- Engagement and retention strategies?
- Discharge planning?
- Context/locations of CHR-P programs?

Community Hope and Resources Program: CHR-P Stepped Care Services in Maine

Rebecca Jaynes, LCPC

Program Supervisor, Portland Identification and Early Referral (PIER)
Community Hope and Resources for Psychosis, MaineHealth

Sarah Lynch, LCSW

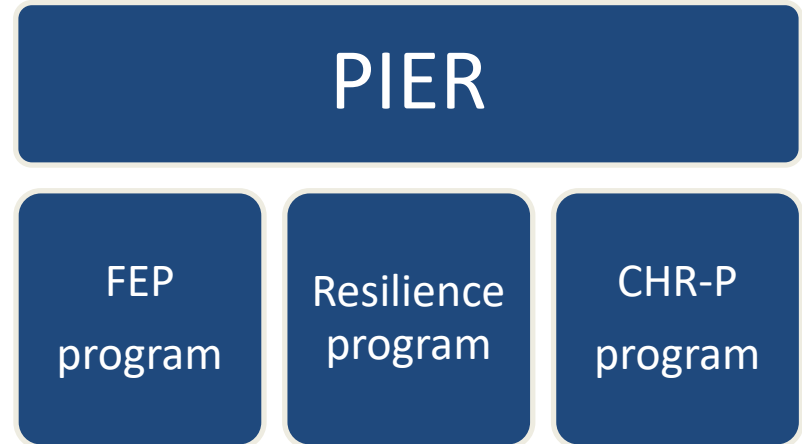
Program Manager, PIER and Resilience, MaineHealth



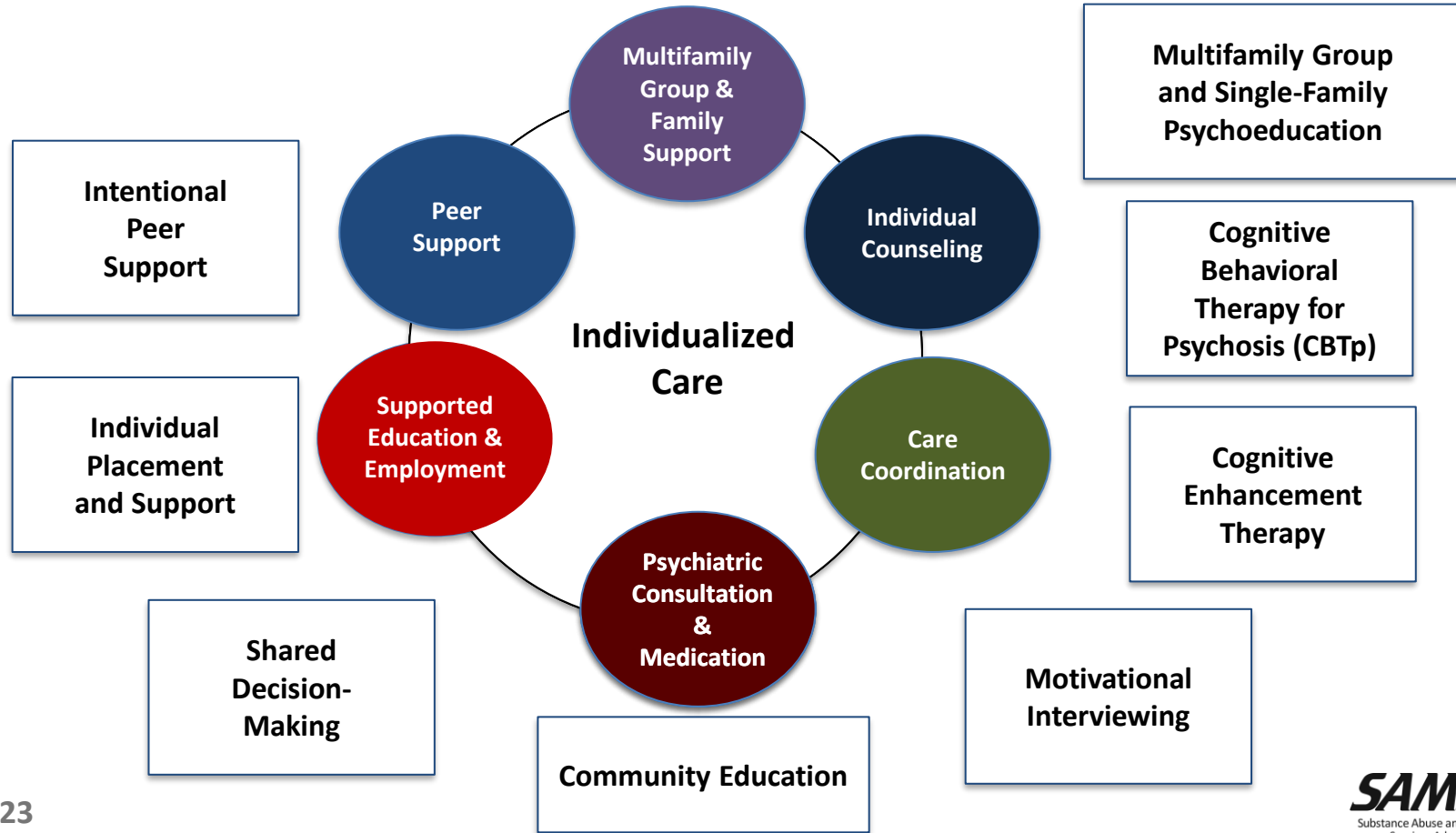
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Portland Identification and Early Referral Program (PIER)

- Providing treatment and conducting research on clinical high risk for psychosis (CHR-P) and first episode psychosis (FEP) since 1999, **starting with CHR-P** (as opposed to FEP)
- Rich network of referral sources, long history of community outreach
 - Getting referrals was no problem (started with waiting list)
 - One referral pipeline (PIER) covers two statewide FEP programs and now CHR-P



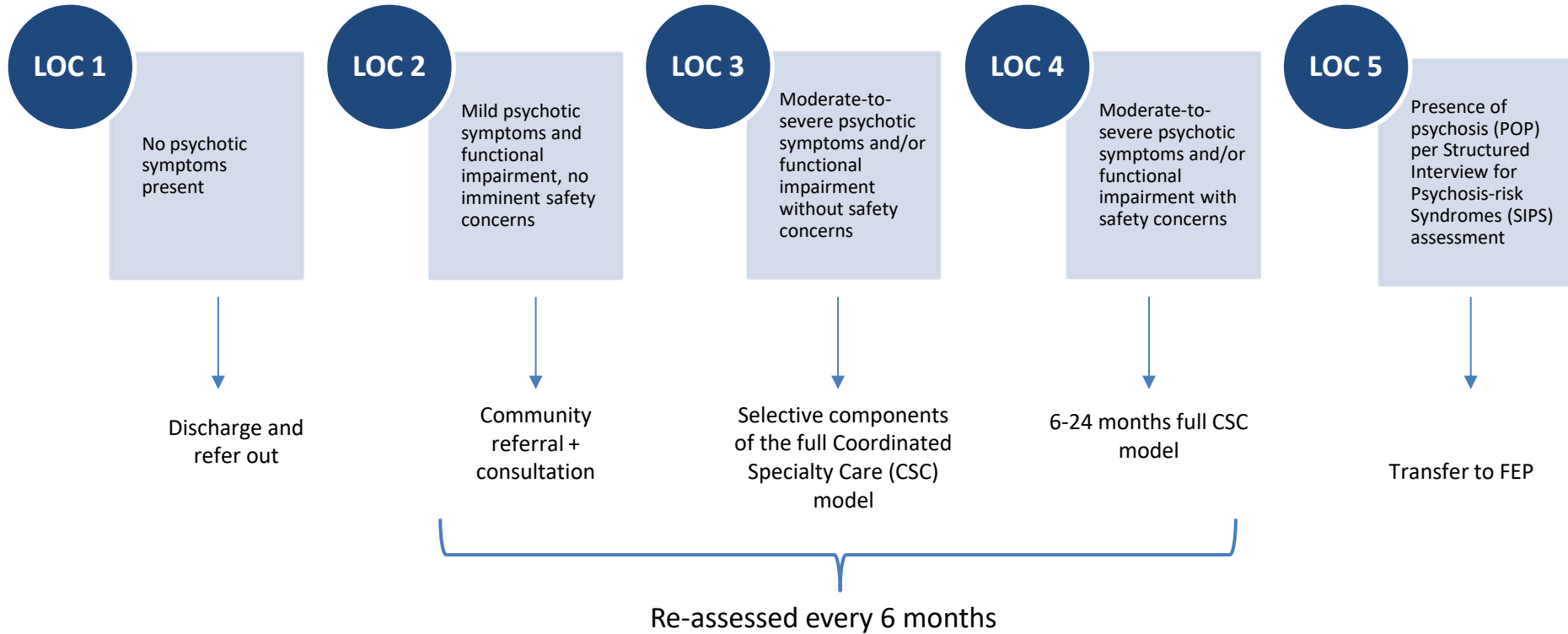
Coordinated Specialty Care (CSC) Model



Mental Health Landscape in Maine

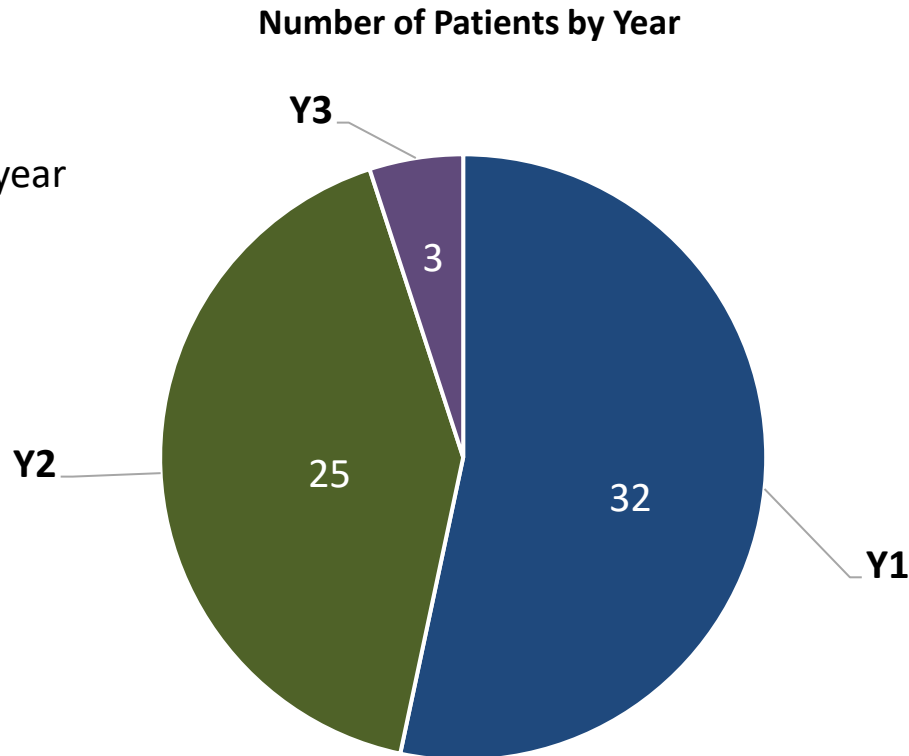
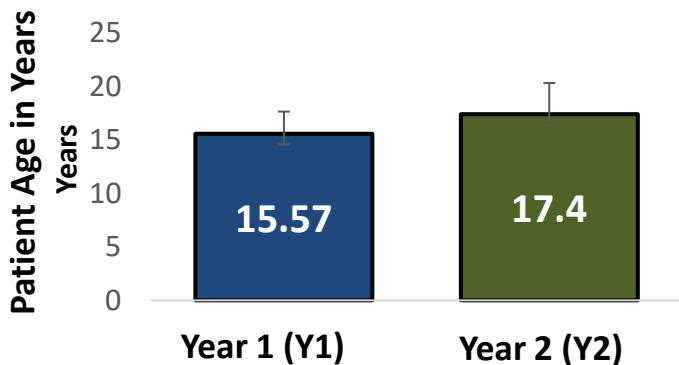
- Second most rural state in the country
- Geographically relatively large
- Very limited mental health services, especially specialty care
- High rates of poverty in rural areas

Levels of Care (LOC)



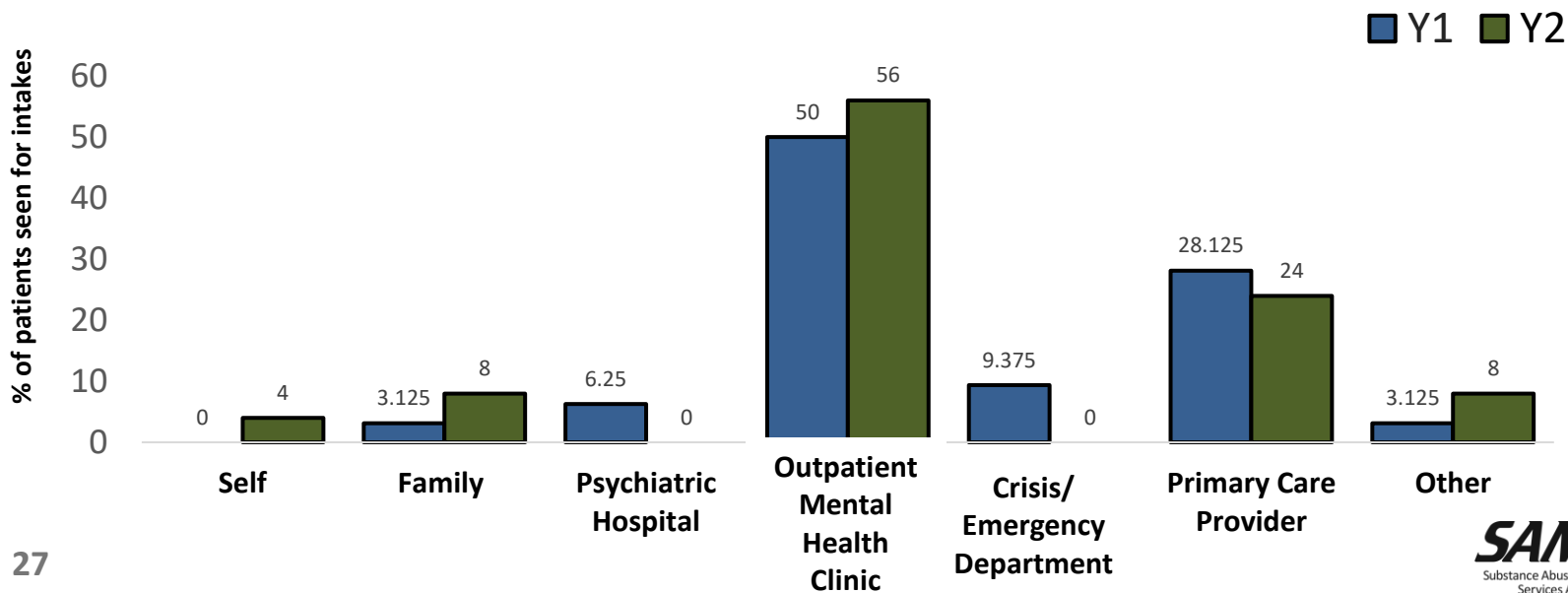
Two Years In...

- Sixty intakes completed since start of program
 - Identified sustainable pace of 24 intakes/year
- Mean age 16 years, 60% female



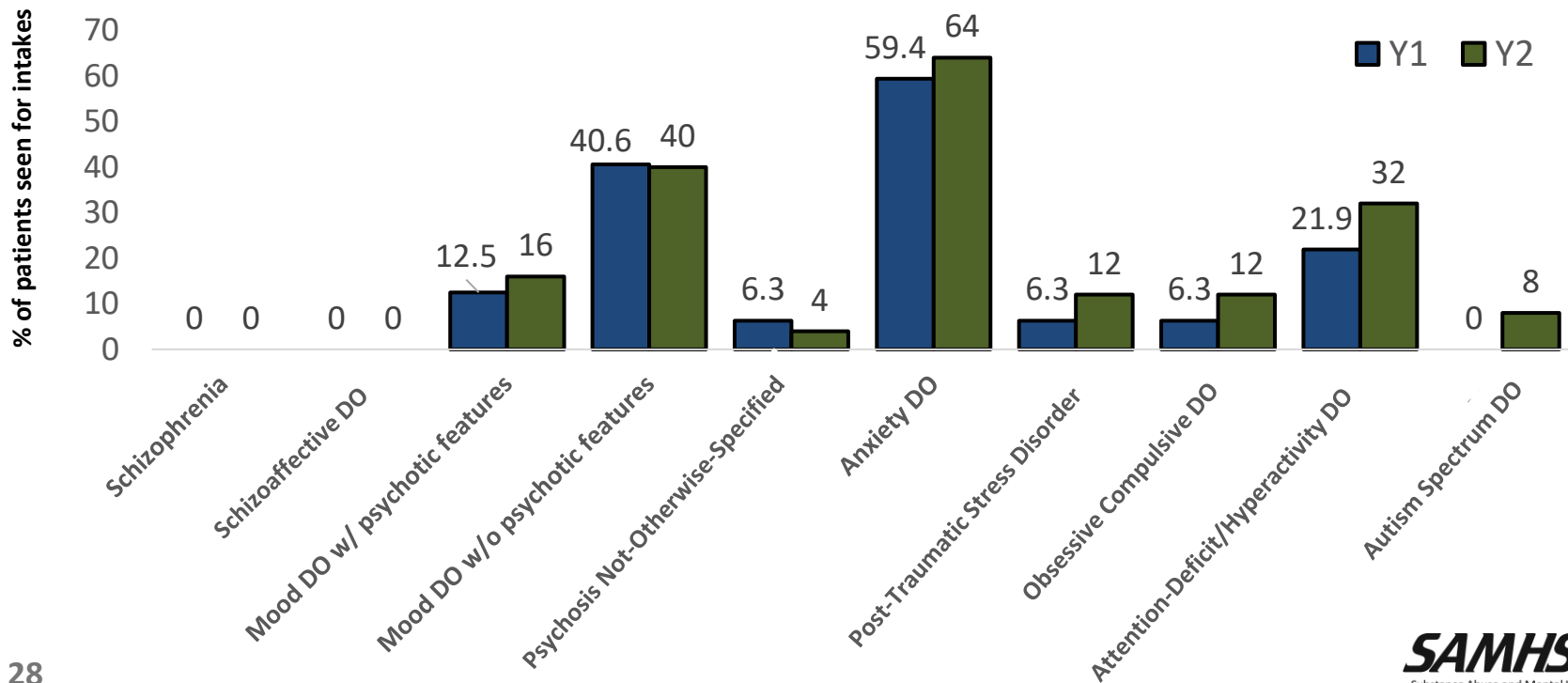
Two Years In...

- Most referred from outpatient mental health and primary care providers
- Growing number of referrals from family/self/other
- Aligned with our community outreach efforts



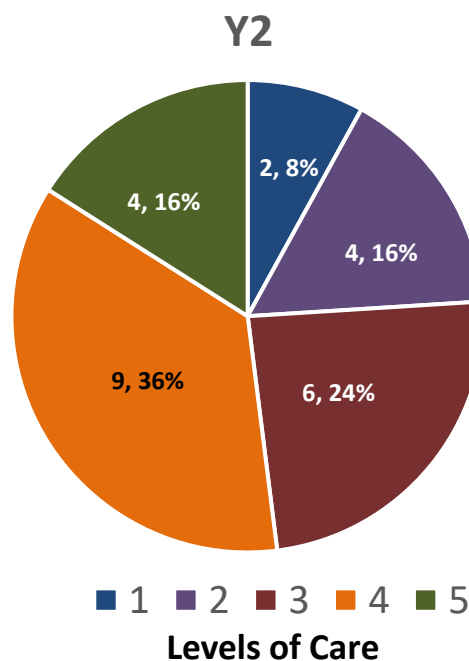
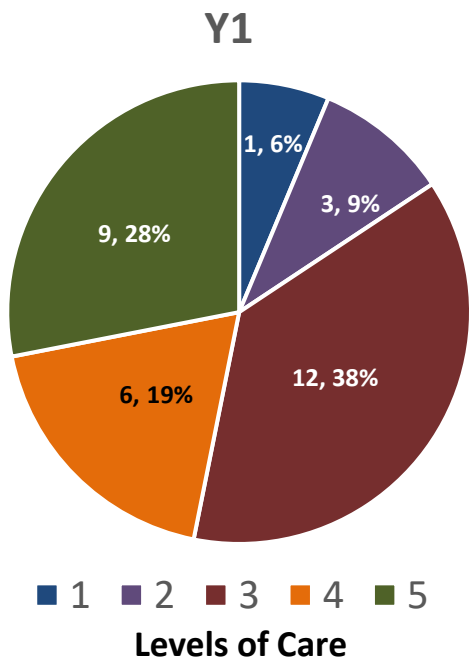
Two Years In...

Most patients had been previously diagnosed with a mood or anxiety disorder (DO)



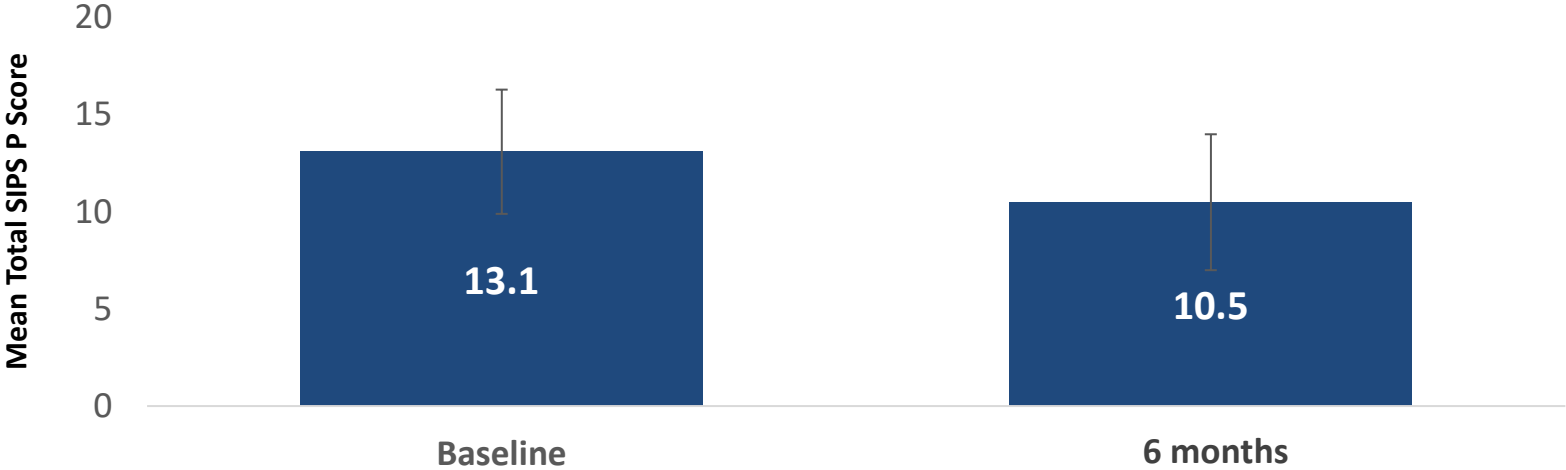
Two Years In...

- Initial level of care stratifications
- Stable at 60% fall in LOC 3 and 4 (CHR-P services) = efficient use of resources



6-Month Reassessments

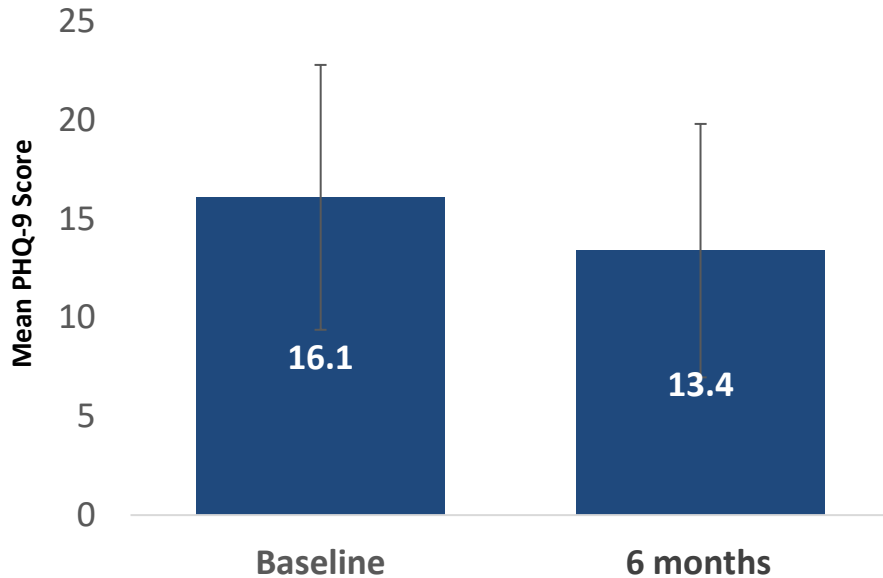
Total Scores on the Structured Interview for Psychosis – Risk Syndromes (SIPS) Positive Symptoms Scale (P-Scale) show improvement at 6-month reassessment from baseline



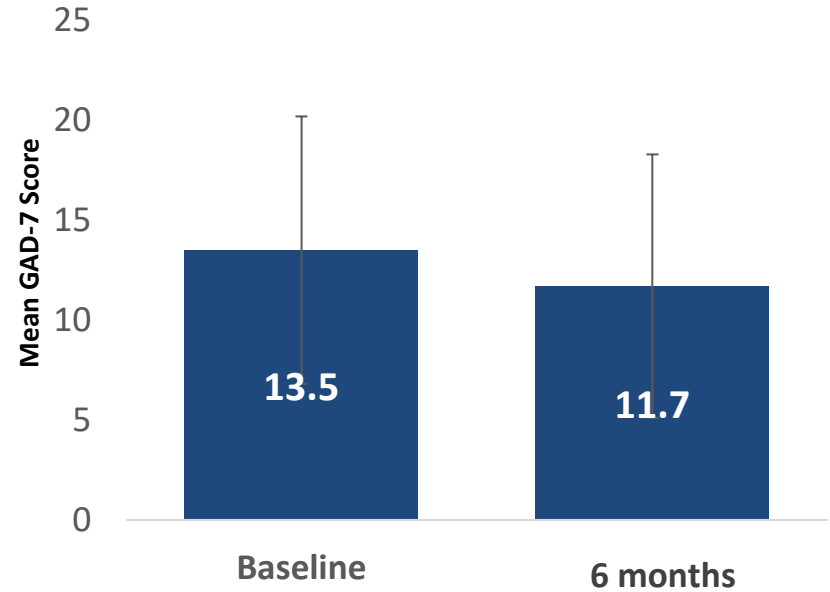
6-Month Reassessments

Depression and Anxiety improved at 6-month reassessment, as measured by the Patient Health Questionnaire (PHQ-9) and the General Anxiety Disorder-7 (GAD-7)

Depression

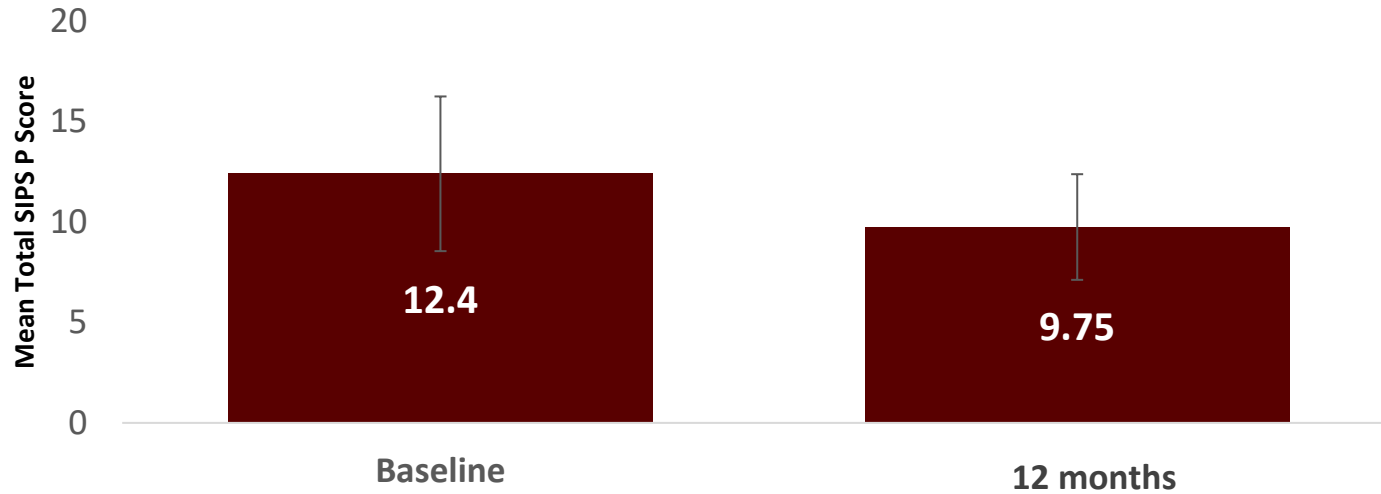


Anxiety



12-Month Reassessments

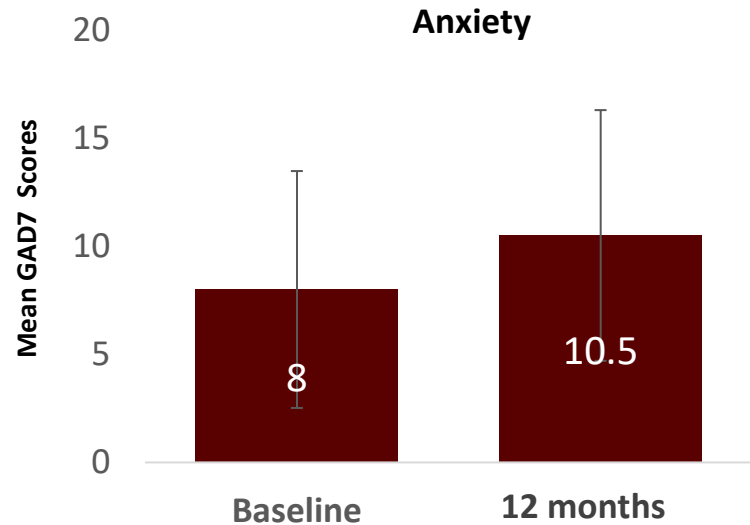
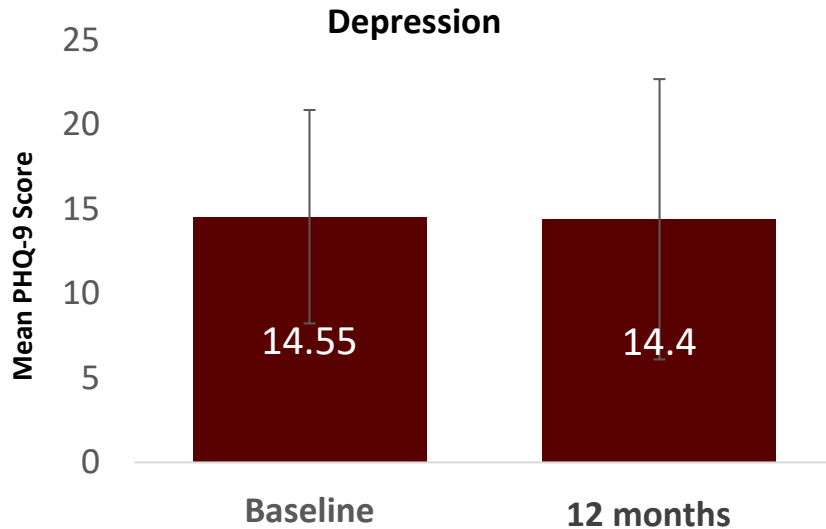
Total P-Scale Symptoms – continued to improve/stabilize from baseline



12-Month Re-assessments

Depression (measured by PHQ-9) remained the same and anxiety (measured by GAD-7) increased at 12 months

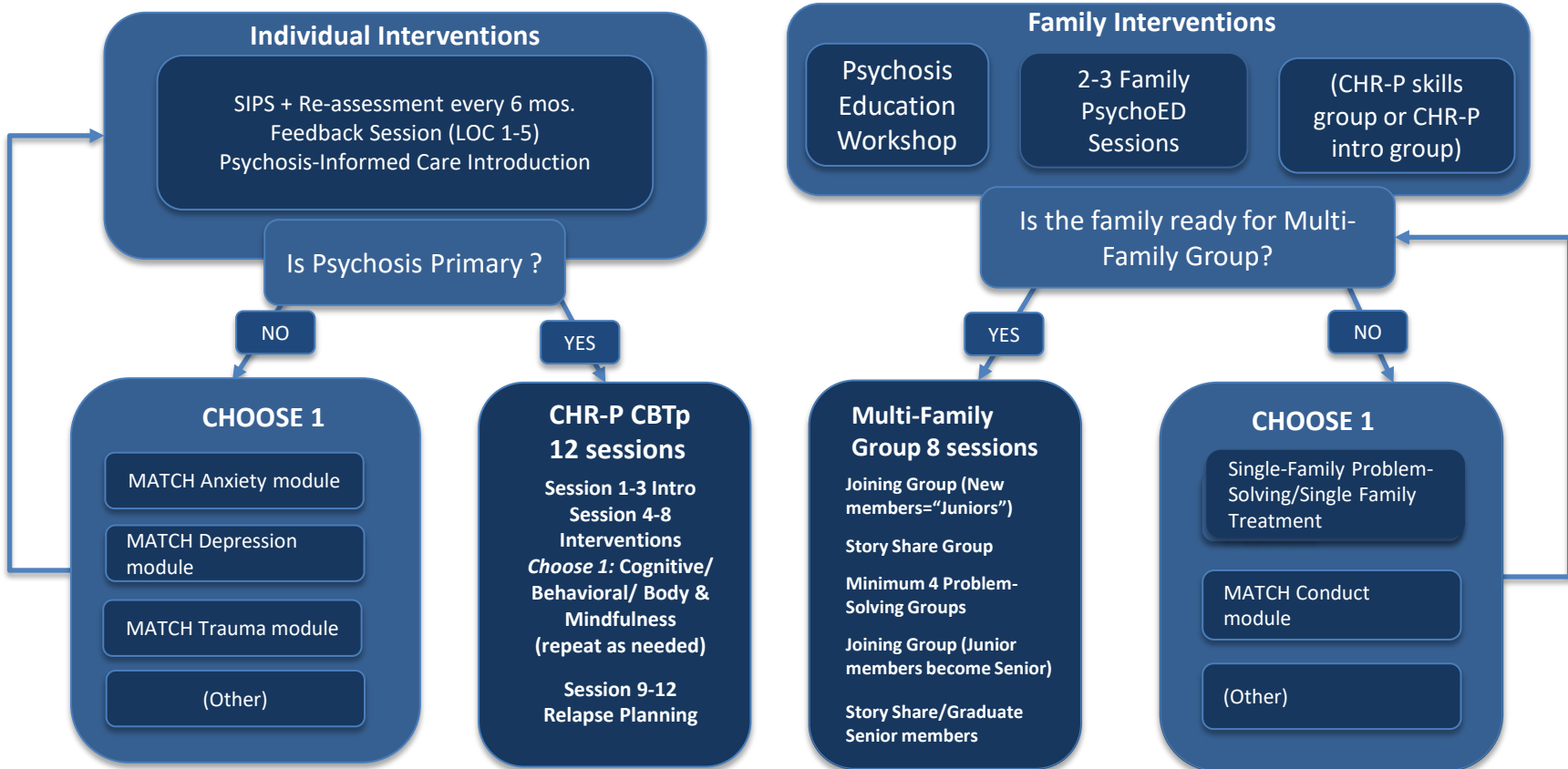
- Participants still involved at 12 months likely addressing more complex underlying needs
 - All Levels of Care have multiple needs in addition to psychosis
- Case Management needed LOC (3) to support discharge
 -so our “# of services” stepped model became problematic



Year 3: Moving from “# of services” model to short-term modules of treatment

- Everyone has access to a case manager, an education/employment specialist, short-term psychoeducation and family modules in the first 6 months
- Formulation-based evidence-based practices to follow (Cognitive Behavioral Therapy for Psychosis for CHR-P [CBT-CHR-P], CBT-Depression/Anxiety/Trauma
 - Hope to continue to show at lower LOCs: shorter duration of treatment, brief modules
 - More consistent treatment exposure across program LOCs
 - Includes proactive discharge planning
 - Necessitates community workforce development goal (LOC 2)

Year 3: short-term modules of treatment, reassessed every 6 months



Learning as we go!

- Continuing to refine
- Open to questions/input, **always**
- Reach out via Pier Training Institute or MaineHealth



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PIER CHR-P Supervisor

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PIER Program Manager

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Prevention and Recovery from Early Psychosis (PREP): Early Psychosis Programs in Utah

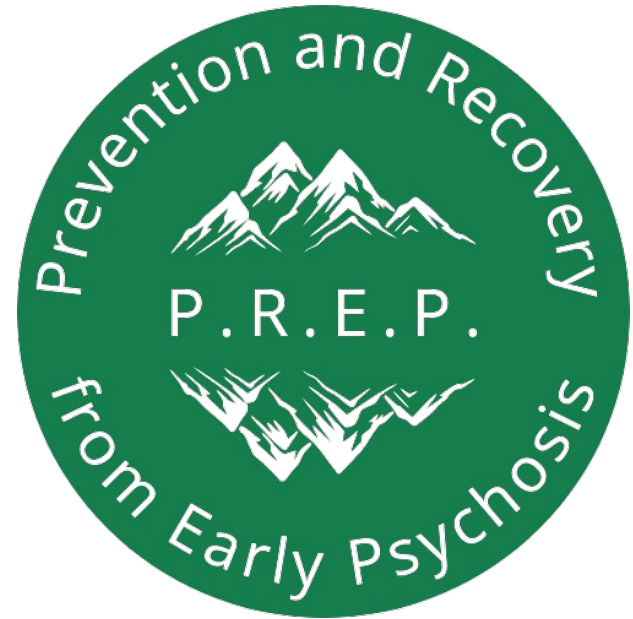
Jessica Makin, MSW

Program Administrator, Transition-Age Youth & Employment Supports
Utah Department of Health and Human Services



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- Prevention and Recovery from Early Psychosis (PREP)
- Started first episode psychosis (FEP) services in 2015
- Received first round of CHR-P funding in 2018; second round in 2022



Program Locations in Utah

- Weber Human Services
 - Weber & Morgan counties
- Davis Behavioral Health
 - Davis County
- Volunteers of America
 - Salt Lake County
- Wasatch Behavioral Health
 - Utah & Wasatch counties

Stepped Care

Our sites have learned a lot through the past 6 years:

- Utilize the weekly team meetings to coordinate and discuss services; collaborative approach is key to making sure clients get services they need
- The team model provides opportunity for different messengers across the team
- Clients can always change their minds about services they want/need
- Make sure the team, client, and family/support system are on the same page
- Community education is critical!

Context of CHR-P Treatment

- All sites are co-located with FEP services
- Three sites located within the public mental health system
- One site at a community-based non-profit
- Co-location creates ease in continuity of care
- Local mental health system sites can refer to other services in their organization once finished with the program

Engagement

Engagement

- Significant engagement focus on the front end of services
- Built-in flexibility at the beginning of services to factor in time for engagement; some families get overwhelmed and need some time to adjust
- Welcome packet

Retention

- Treatment team reviews
- Weekly team meeting / coordination

Discharge Planning

- Clarity about time-limited program from the start
- Regular conversations about transitions and next steps
- Co-location creates continuity of care
 - Sites have the ability refer to other services at their organization

Stepped Care to Scale-Up Expert Treatment for those at Clinical High Risk for Psychosis: The Sacramento Clinical High Risk Intervention for Psychosis Stepped Care (SCIP Step) Program

Daniel I. Shapiro, PhD

Associate Professor, Sacramento CHR Intervention for Psychosis Stepped
Care (SCIP Step) Program, University of California Davis



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Stepped Care at a Systems or Local Population Level

This fantastic panel demonstrates the promise and flexibility of stepped care.

At a systems level, there is potential to address *significant barriers* to identifying all help-seekers with elevated risk for psychosis and fitting appropriate care:

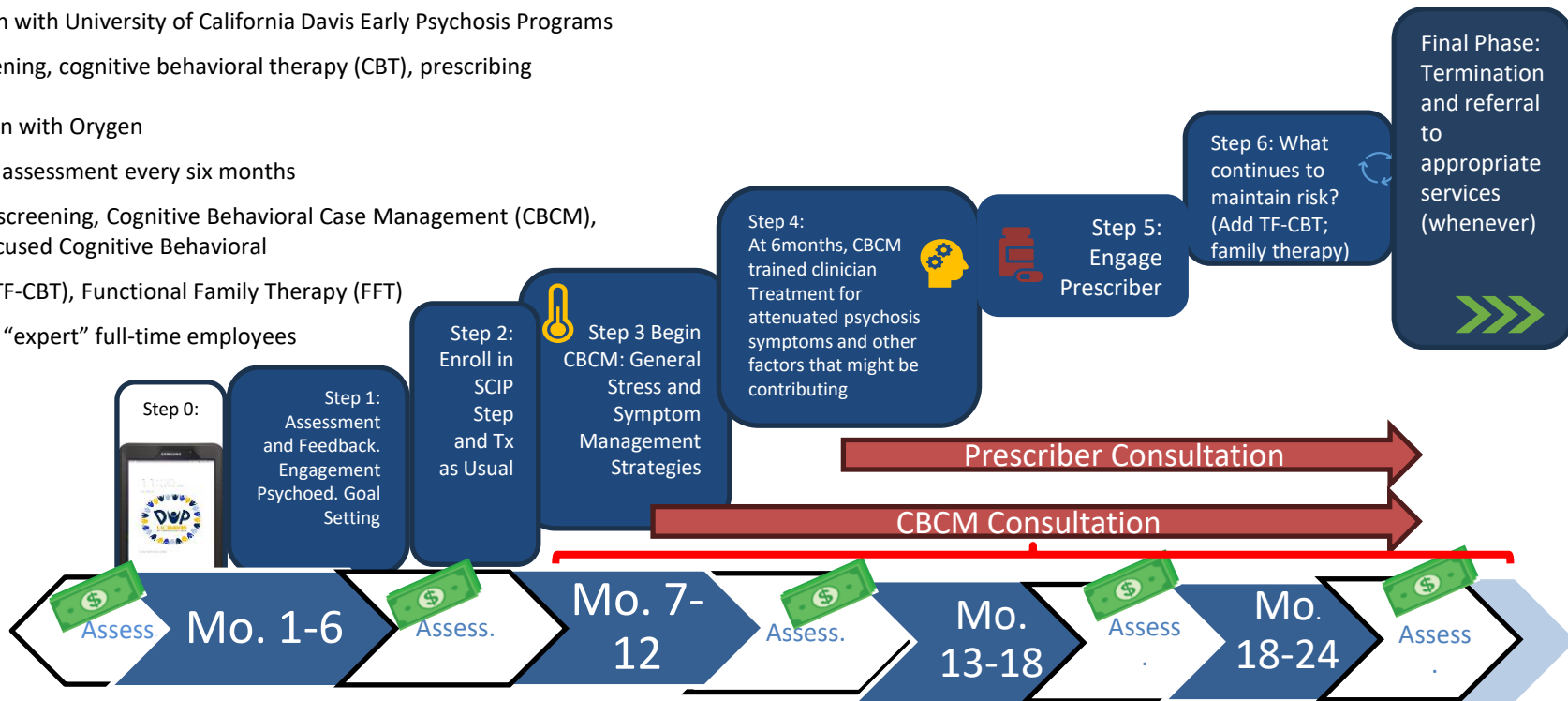
- Knowledge of indicators, signs, and symptoms of risk in the community
- Availability of expertise in evidence-based assessment and interventions
- Ability to treat the diverse intensity and types of need in this heterogeneous and highly comorbid population
- Accessibility: Care that is provided within one's community, in an affirming way, by providers who are more likely to understand and share your customs and values
- Ability to manage multi-finality through re-assessment of needs, connection to other services, availability of other specialized care teams
- Workforce issues: training, turnover, workforce shortages

Partnership: Sacramento County Dept of Behavioral Health & UC Davis Early Psychosis Program

- Sacramento County = 1,584,169 per census.gov
- Care for those with public insurance is coordinated
 - Adolescent and young adult clinics independently developed then contracted with the county and private insurance companies
 - Centralized access points, coordinated assessment procedures, support for linkage
 - As needs are identified, contracting can shift the services landscape to meet them
- Clinical high risk rough point prevalence: 2 to (4-8)%
 - ~31,700 at 2%, not taking age into account
- One specialty care early psychosis center
 - In the best of times, census around 200 including assessment and step-down
- Multiple youth-focused clinics located around the county, structured to address various levels of need
- Implement identification and stepped care treatment in community clinics

Sacramento CHR-P Stepped Care Program (SCIP-Step)

- **Modified Community-Based Case Management (CBCM)**
- Embedded within standard community care at 5 Community Mental Health (CMH) agencies (9 clinics)
- Consultation with University of California Davis Early Psychosis Programs
 - Screening, cognitive behavioral therapy (CBT), prescribing
- Consultation with Orygen
- Specialized assessment every six months
- Training in screening, Cognitive Behavioral Case Management (CBCM), Trauma-Focused Cognitive Behavioral
- Therapy (TF-CBT), Functional Family Therapy (FFT)
- Less than 3 “expert” full-time employees



Reassessment by UCD every 6 months

Clinical High-Risk (CHR-P) Syndrome/ Attenuated Psychosis Syndrome

Within Cultural Norms

- No distress
- Infrequent/rare
- No effect behavior/functioning
- Consistent with cultural beliefs

- Attenuated positive symptoms
- New or worsening
- Some distress, bothers them
- Able to question reality

- Increasing frequency (weekly → daily)
- Increasing distress
- Seems real, but not convinced
- Affects behavior or functioning

Full threshold Psychosis

- Significant distress
- Frequent (weekly, daily)
- Convinced it is real
- Affects behavior
- Impairs functioning

Exit Project
Continue care as usual
No more monitoring
Referral to other specialty care

Exit Project
Refer to SacEDAPT (Early Diagnosis & Preventative Treatment Clinic), specific care plan

- General adult, transition-age youth (TAY), child programs for longer-term care
- Higher/lower level of care
- Adjunctive services (therapeutic behavioral services [TBS])
- Other specialty care (autism spectrum disorder [ASD], alcohol and other drugs [AOD])

Staffing and Settings

UC Davis

Dan Shapiro, PhD
Principal Investigator



Sabrina Ereshefsky, PhD
Assessment Director



Yen-Ling Chen, PhD
Post-Doctoral Fellow
Seohyun Joo, PsyD
Bilingual Clinician



Alvaro Gonzalez, MA AMFT
Bilingual Clinician



Shirley Yau, BS, BA
Project Coordinator

Tammi James, MD

All except Shirley
have roles in our
clinic

[They attend clinic meetings
for coordination.]

Sacramento County

Maria Pagador
Mel Planas, LCSW

Flexible Integrated Treatment Community Clinics

River Oak Center for Children
(2 clinics)

UC Davis Child and Adolescent Abuse Resource and
Evaluation (CAARE) Center

Heartland Child and Family Services
(3 clinics)

Capital Star Community Services
(2 clinics)

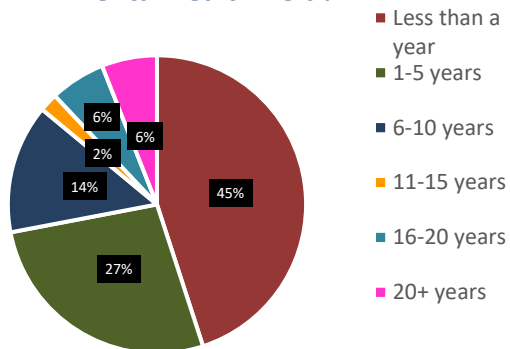
Turning Point Community Programs

Goals: Number of Unduplicated Individuals Served with Grant Funds

	Yr 1	Yr 2	Yr 3	Yr 4	TOTAL
PQ-B Screen Eligible	300	600	900	900	2700
PQ-B Screen Positive	117	234	351	351	1053
Complete CHR-p SCIP Evaluation	80	159	239	239	716
Enroll in Stepped CHRP Treatment	22	44	66	66	198

Workforce Capacity

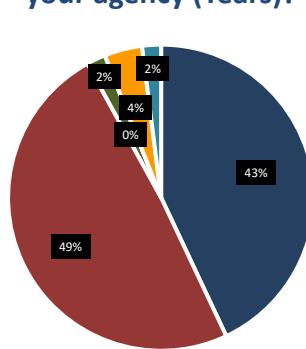
How long have you been in the mental health field?



Professional Background

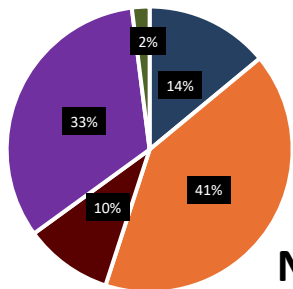
N=49

How long have you been with your agency (Years)?

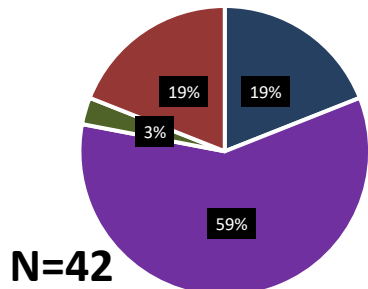


Professional Status

N=49



N=37



N=42

- Clinical Psychologist
- Clinical Social Work
- Counseling Psychologist
- Marriage & Family Therapist
- Student
- Associate Masters Level

- Trained: 167 screening, 60 Cognitive Behavioral Case Management (CBCM)

- 28 clinicians consented, 6 Barriers & Facilitators (B&F) interviews

- High turnover in clinic staff

- Experienced leadership
- Predominance of unlicensed and trainee staff, and many move on after licensure

- Incredibly varied background and experience with CBT

- Disseminating v. teaching v. unlearning

- **Less experienced clinicians:** Consider more structure in interventions for those with less experience/training

- Handouts, brief structured interventions, 'Cognitive Behavioral Therapy (CBT) informed' skills

- Time for consult/workgroups

- Include supervisors and leadership!

- Live v. asynchronous training

- Pros and cons to each

Gratitude to amazing project teams



SCIP Step team

- Sabrina Ereshefsky
- Shirley Yau
- Alvaro Gonzalez
- Yen-Ling Chen
- Tara Niendam
- Dan Shapiro

Orygen

- Barnaby Nelson

Sacramento Department of Health Services - Behavioral Health

- Melissa Planas
- Maria Pagador
- Rob Kesselring

Phenomenal clinicians, clients, and families in our 9 clinics

River Oak Center for Children

- Tina Traxler
- Karen Vang

UC Davis Child and Adolescent Abuse Resource and Evaluation (CAARE) Center

- Dawn Blacker
- Heather Zyla

Heartland Child and Family Services

- Jerri Ford
- Todd Palumbo

Capital Star Community Services

- Nicole Stiving
- Elisa Duran
- Gina Leveroni

Turning Point Community Programs

- Marcia Gump
- Marisa Ciani
- Jennifer Mashburn

Thank you for your interest and attention!



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Questions?



Dan Shapiro (dishapiro@ucdavis.edu)

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Upcoming ESMI TTA Center Webinar

- **Early Serious Mental Illness and Substance Use**
 - Date & Time: February 18, 2025 @ 12 PM EST
 - Presenters: Melanie Bennett, PhD, Corinne Kacmarek, PhD, Samuel Murphey, MSW
- **Suicide Prevention Best Practices for Individuals at Clinical High Risk for Psychosis or Experiencing First Episode Psychosis**
 - Date & Time: March 18, 2025 @ 12 PM EST
 - Presenter: Christa Labouliere, PhD
- **Cognitive Health in the Coordinated Specialty Care Context**
 - Date & Time: April 15, 2025 @ 12 PM EST
 - Presenter: Ali Saperstein, PhD



<https://tinyurl.com/esmittac-webinars>



Your feedback on today's webinar is greatly appreciated!

Thank You

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

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