EASA Center for Excellence

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Clinical High Risk in Early Psychosis Intervention: Assessment and Treatment

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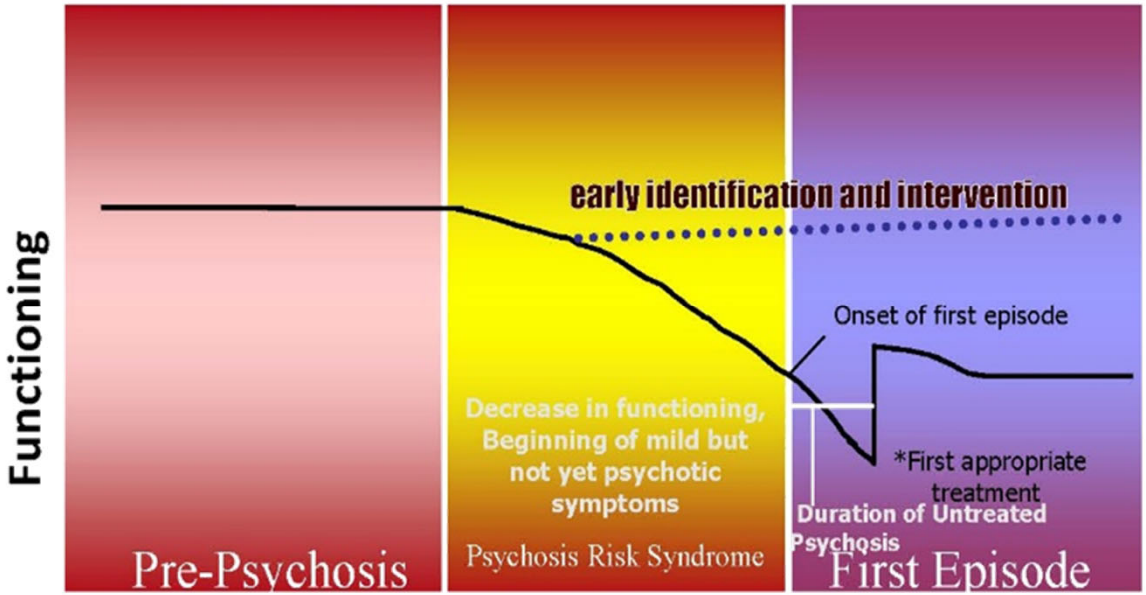
Objectives:

Learn about current research in clinical high risk for psychosis
Distinguish between assessment, engagement, and treatment in clinical high risk for psychosis vs. first episode psychosis
Become familiar with psychoeducation resources and materials specific to clinical high risk for psychosis

Clinical High Risk for Psychosis

Developed from research into schizophrenia clinical high risk for psychosis phase
Early stages of schizophrenia have high levels of acuity, involuntary treatment/legal involvement/suicide
First Episode Programs will naturally move toward Clinical High Risk for psychosis as they attempt to identify psychosis early/reduce duration of untreated psychosis (DUP)
School/work impact often begins before acute level with onset of cognitive changes

Phases of Psychosis



McGlashan, 2001

SAMHSA
Substance Abuse and Mental Health Services Administration

At Risk Psychosis

- Also referred to as:
  - Ultra High Risk (UHR)
  - Clinical High Risk (CHR)
  - Prodromal Psychosis
  - Attenuated Psychosis Syndrome (APS)
  - Psychosis Risk Syndrome (PRS)
- Valid and reliability tools to identify and diagnosis
  - Screening tools (Prime Screen, Prodromal Questionnaire Brief, Early Psychosis Screener)
    - (Miller et al, 2003) (Loewy et al, 2011) (Brodey, 2019)
  - Assessment tool (Structured Interview for Psychosis Risk Syndrome)
    - (McGlashan, 2014)
- Active treatment is recommended at this stage

Structured Interview for Psychosis-Risk Syndromes

- Attenuated Positive Symptom Syndrome (APSS)
- Brief-Intermittent Psychotic Syndrome (BIPS)
- Genetic Risk and Deterioration Syndrome (GRD)

McGlashan (2014)

Symptoms of Clinical High Risk vs. First Episode Psychosis: What are the differences?

Clinical high risk symptoms can range from hardly noticeable to obvious and can occur over days, months or even years

Impact on school and/or work often begins before the acute level with onset of cognitive changes

Unlike first episode psychosis, the young person with CHRP will retain awareness that their experiences are different than their usual experiences but cause some distress

Individuals are more likely to seek assistance for these experiences than individuals diagnosed with first episode psychosis.

Some common clinical high risk symptoms:

- ✓ Sensitivity to light, touch and sounds
- ✓ Trouble concentrating, paying attention, and with memory
- ✓ Having a hard time understanding others and being understood when talking
- ✓ Increased suspicion and fear without a known reason
- ✓ Momentarily thinking they see or hear something that is not there
- ✓ Unusual ideas or behavior that is new and different for them
- ✓ Struggles in school, at work or with family/friends
- ✓ Withdrawal from important people in their lives
- ✓ Depression
- ✓ Lack of motivation and/or energy
- ✓ Sleep challenges
- ✓ Change in appetite

It is usually a combination of these symptoms, rather than just one, that suggest the presence of clinical high risk for psychosis

These symptoms can also be explained by other mental health conditions, big life changes, stressors, or may be typical experiences of being a young person

A SIPS assessment completed by a trained EASA team member will explore possible explanations for these symptoms

In most situations, symptoms of CHRP start gradually, but are **new and uncharacteristic** of the young persons' experiences, personality and behavior

Individuals can meet criteria for CHRP without neurocognitive changes or functional decline

It is important for all EASA team members to know whether a young person in EASA meets criteria for CHRP and to clearly communicate this information to participants and family members (with participant permission).

If a young person is receiving EASA services for symptoms of psychosis risk syndrome they will need to be carefully monitored to assess any increases and/or improvements in symptoms, both for the purposes of clarifying diagnosis and so that treatment with EASA can be adapted to address their specific needs.

Monitoring of symptoms should involve a trained SIPS interviewer using the SOPS scale every 90 days, unless the individual scores a 5 on P1 or P2, in which case monthly SOPS scales are indicated.

The majority of individuals who convert from psychosis risk syndrome to first episode psychosis convert within a year.

If conversion to first episode occurs while in EASA the recommendation is that the individual's two years in the early intervention program re-starts.

EASA teams can also use other symptom-based assessments for individuals meeting criteria for CHRP, using scales such as the Patient Health Questionnaire (PHQ-9) for depression, the GAD-7 for Generalized Anxiety Disorder, and/or trauma assessments.

It is also recommended that alliance and outcome measures such as the PCOMS (Partners for Change Outcome Management System) are used.

Treatment for Clinical High Risk for Psychosis

Treatment for individuals brought into EASA under the SIPS should include:

- ✓ Cognitive Behavior Therapy for Psychosis (CBTp) using insight oriented strategies (reality testing, experimentation) or CBT for co-occurring disorders such as depression, anxiety, and/or trauma (Van der gag, 2017)
- ✓ Individual Placement and Support model of supported employment and/or education focused on developmentally appropriate recommendations
- ✓ Peer Support Services focused on non-diagnosis related experiences
- ✓ Occupational Therapy (several screening and assessment tools and interventions specific to executive functioning, sensory strategies, emotional regulation, etc.)
- ✓ Specialized prescriber services that are based in building engagement, rapport, psychoeducation for the individual and the family/supports, and that include collaboration with team members to monitor for conversion to first episode psychosis

Treatment for Clinical High Risk for Psychosis

Treatment for individuals brought into EASA under the SIPS should include:

- ✓ Nursing focused on: typical health and wellness, including initial health questionnaire, connection to PCP, baseline labs and psychoeducation
- ✓ Strengths-based case management focused on resources, ability to cope, focusing on informal helping network and resources (Rapp, 2005). Resources focused on stress reduction as opposed to disability resources.
- ✓ Individual and Family psychoeducation focused on: education about CHRp, prevention strategies, communication skill-building, and problem-solving and avoiding labels/self-stigma

  Cultural minorities may feel more stigmatized (Wong, 2017)

  Symptoms may be more stigmatizing then label, focus on self stigma (Yang, 2015)

  Substance use risk reduction, especially cannabis use

  Focus on cannabis use as risk of transition especially those with SUD (Carney et al, 2017)

  CHR clients use for mood enhancement & social motives (Gill, 2015)

Additional notes:

Research shows antipsychotic medications cause more risk than benefit with this population unless there is significant deterioration

Monitor metabolic risk with or without medications (Shah, 2019)

Treatment for Clinical High Risk for Psychosis:

Frequency of early intervention services for those diagnosed with psychosis risk syndrome is a minimum of every two weeks, with an increase or reduction in services guided by clinical measures
Recovery with clinical high risk for psychosis varies depending on the individual
Sometimes symptoms go away with treatment and support and do not return
For others, symptoms progress into symptoms of psychosis
Receiving treatment and support right away can make a significant difference for a young person experiencing psychosis risk syndrome.

Psychoeducation Materials for CHRp

Focus on developing a common understanding of participant's CHRp symptoms and progression of symptoms, including sensitivity to stress and stimulation

Developing and practicing participant and family/support system coping strategies related to symptoms

Focus on information sharing based on the participant and family members/supports unique and evolving experiences

Adapt and change materials over time during EASA treatment based on individual and family member/support system experiences

Questions or comments so far?

Let’s Breakout

Resources

- Uploaded to Learning Management System:
  - The Integration of Early Psychosis in a System of Care Framework http://med.stanford.edu/content/dam/sm/peppnet/documents/Integration-of-Early-Psychosis-Services-in-SoC-Framework-Final.pdf
- NASMPHD materials: https://www.nasmhpd.org/content/early-intervention-psychosis-eip
- PEPPNET (click "contact us" to join if you haven't!): https://med.stanford.edu/peppnet.html
- Webinars and handouts (2 videos by Barbara Walsh on CHRp assessment and treatment): http://www.easacommunity.org/national-resources.php
- Dr. Melton TED Talk: https://www.youtube.com/watch?v=ws-N4gGSER0

- EPSI: https://telesage.com/eps/
- PQ-B instructions for Clinicians: https://easacommunity.org/PDF/PQ-B_InstructionsforOutreach.pdf
- Online PQ-B: https://easacommunity.org/documents/p.848.2-pq-b_12-08.doc
- Structured Interview for Psychosis-Risk Syndromes (SIPS)*: https://easacommunity.org/PDF/SIPS_5-5_032514[1]%20correct.pdf
- Structured Interview for Psychosis-Risk Syndromes in Spanish*: https://easacommunity.org/PDF/SIPS-4Espanol.pdf

  *You must be trained and certified in the SIPS to use it in clinical practice
- Mini-SIPS: https://yalesurvey.ca1.qualtrics.com/jfe/form/SV_3afko0rPjgAX1dj

Wrapping Up

What have you learned?

Did we meet our goals today?

What areas does your team need to focus on more moving forward?

Questions?

Feedback

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