Adverse Childhood Experiences, Serious Mental Illness/Substance Use Disorders and Tailoring First Episode Psychosis (FEP) Programs to Serve Women

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Thank You, Phil!

- Data presented from McLean OnTrack courtesy of Phillip Benjamin Cawkwell, MD
Objectives

• Explore treatment environments for women with co-occurring first episode psychoses (FEP), substance use disorder (SUD), and histories of trauma.

• Identify knowledge gaps and areas for improvement.

• Discuss educational needs of the workforce caring for this vulnerable population.
Part 1: Discuss data from McLean OnTrack Outpatient Program and care environment with case study.

Part 2: Briefly explore psychotic disorders inpatient treatment environment and community links with case studies.

Part 3: Identify educational needs of the workforce and specific areas for improvement.
Outpatient FEP care environments: Experiences from McLean OnTrack
What is McLean OnTrack?

- Outpatient FEP program
  - 2-5 year timeframe
  - Psychosis onset in past year
- Chronicity is not an option!
- Transdiagnostic
- Integrated wellness approach
- Flexible approaches to care/engagement
- Light touch to psychiatric medications
- Functional recovery over symptom recovery
Clinical structure of McLean OnTrack

**DIALOGIC TEAM APPROACH**
Peer specialist, social workers, nurses, psychiatrists, psychologists

- Recreational and process oriented groups
- "Job Club" and individualized vocational support
- Recovery oriented individual psychotherapy
- Biological interventions geared towards FEP
- Family psychoeducation and support
- Case management

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Many more men treated than women . . .

N=49 women

Gender Differences in McLean OnTrack

- Why the disproportion?
- Are there factors influencing pathways to care?
- Is this common?
- How and why is this problematic?
Gender differences of trauma in McLean OnTrack

- Significantly more women than men endorse trauma, and of those women who endorse trauma, the most common type is sexual abuse.

Types of Trauma for Women in McLean OnTrack (N=22)

- Physical and sexual
- Physical and emotional
- Physical abuse alone
- Sexual abuse
Gender differences of substance abuse in McLean OnTrack

- Significantly more men than women abuse substances. Of those women who abuse substances, cannabis is the most common.

### Types of Substances Abused by Women in OnTrack (N=33)

- Cannabis
- Cocaine
- Stimulants
- Hallucinogens
- Opiates
- Sedatives/Hypnotics
Cannabis is problematic for both males and females and is present across psychosis categories.
Gender differences of trauma + substance abuse . . .

- Significantly more women have both trauma and substance abuse histories when compared to males.
• Women with T+SA in McLean OnTrack may be more likely to have affective psychosis (approaching statistical significance p=0.079)
  • Limits access to traditional FEP resources?
  • Treatment programs are still structured to accommodate more typical FEP.
No differences in regard to . . .

• No differences between women with trauma + substance abuse compared to the rest of the McLean OnTrack group in regard to . . .
  – Insight into illness
  – Referral source
    • Largely inpatient units
  – Age
  – Number of hospitalizations at baseline
*Real World Outcomes?

- Women without trauma and substance abuse are more likely to be college graduates and have attained their graduate degrees.
Treatment Outcomes?

- Women with trauma and substance abuse histories are significantly more likely to disengage from treatment earlier than the rest of the individuals in the McLean OnTrack program.

![Graph showing Kaplan-Meier survival estimates]

RED = women with T+SA  BLUE = OnTrack group

(p < .03)
Addressing the issue in McLean OnTrack

- Clinical training in DBT
- Rolling with resistance
- Non expert stance
- Women’s group (new)
- Flexing age range (>= 35 years)
- Finnish Open Dialogue model
  - Humanistic approach
  - Tolerating uncertainty
  - Decrease isolation
Case example

Interrupting the cycle
Areas for improvement . . .

• Increase support groups geared towards women
  – Women and pregnancy
  – Substance abuse
  – DBT
• Aesthetics of OnTrack space
• Better public awareness
• Better recruitment
• Female peer specialists
Inpatient care environments: McLean psychotic disorders inpatient unit
• Two 21 bed adult inpatient units

• Men and women
  – Many are referred from community emergency rooms experiencing acute psychotic episodes.
  – Commonly struggling with access/adherence to treatment in community

• Psychotic disorders
  – First episode psychosis
  – Bipolar disorder, schizophrenia spectrum disorders
  – Substance induced psychosis
    • Cannabis use
Care Environment

• Rooms
  – Single and double occupancy

• Wings
  – Higher acuity wing
  – Not separated by gender

• Communal areas

• Male and female staff
Care Environment

• Open Dialogue model for daily rounds
  – Active involvement of patient
  – Patient centered language

• Sensory Interventions

• Substance use consults
  – Motivational interviewing

• Crisis Prevention Planning
  – Linking back to community services such as DMH case management, co-occurring treatment programs, partial hospitalization, day programs, club houses and PACTs
  – Assist with transition out of the hospital and prevent readmission
• PACT
• OnTrack
• Hill Center
  – Residential program (2 weeks) for women with trauma histories and concurrent mood disorders
• Appleton
  – Residential program (3 months) for adults with bipolar disorder or schizophrenia as primary diagnosis and co-existing conditions such a substance use disorder

Gaps:
• Socioeconomic
• Lack of preventive services in community
• No prior knowledge of prodromal symptoms
Re-traumatization

• Treated as number

• Focus on labels

• Lack of choice, non-collaborative approach

• No opportunity for feedback, not feeling heard

Trauma Informed

• Individualized care - gender specific

• Person centered language

• Involvement in treatment planning, offer choices when possible

• Rounds structure, dialogic approach

(Institute on Trauma and Trauma-Informed Care, 2015)
Single black female, late teens (infant placed with relatives)

**Trauma history** – IPV (boyfriend, father of child), possible ACEs (abuse)

**Substance use** – Cannabis

**Admitting symptoms** – paranoid delusions, auditory hallucinations, assaultive (kicking, punching, spitting) behaviors

**Approach** – Female staff, conscious of trauma history, focus on person as separate from illness. Supported with boundaries with boyfriend, created safe space.

**Outcomes** – She was engaged in treatment decisions. Family involved in treatment and aftercare plan.
Areas for Improvement

• Unit design
  – Women on unit can report
    • Fear from male patients
    • Discomfort with male staff doing safety checks
    • Discomfort with using shared bathrooms

• Additional training in trauma informed education, ACEs and specific developmental trajectories with women.
Workforce Development
Importance of creating supportive and validating environments for women that acknowledge a relational context (Salter & Brechenridge, 2013).
• Women with trauma histories struggle with fragile treatment alliances complicated by stressful life events, substance use and emotional reactivity (Najavits, 2013).
• Women are more likely to internalize problems, especially within the family system. Men are more likely to display aggression (Caton, Xie, Drake & McHugo, 2014).
Cycles of trauma, psychosis, substance use

Increased vulnerability to:
- Future trauma
- Poor treatment adherence
- Poor social support
- Substance relapse

Developmental functioning:
- Emotional sensitivity
- Family problems
- Impaired cognition
- Less education

(Mayo et al., 2017)
<table>
<thead>
<tr>
<th>Organizational level</th>
<th>Clinical level</th>
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</thead>
<tbody>
<tr>
<td>Communicating the message</td>
<td>Non-authoritative, non-expert approaches</td>
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<tr>
<td>Training clinical and non-clinical staff</td>
<td>Screening for trauma</td>
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<tr>
<td>Creating a safe environment</td>
<td>Communication with referral sources</td>
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<tr>
<td>Preventing secondary trauma</td>
<td>Training staff in trauma-specific approaches</td>
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<tr>
<td>Prioritizing a trauma-informed workforce</td>
<td>Care communities</td>
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<tr>
<td>Including patients in decision-making</td>
<td>(Menschner &amp; Maul, 2016)</td>
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</tbody>
</table>
Same questions ????????

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- How and why is this problematic?


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