Quarterly Webinar Addressing Issues in First Episode Psychosis

Brief Review of Year 3 TA Products
In Depth Presentation on CBTp and Issues in the Treatment of Affective Psychosis

November 15, 2017
Overview of the Presentation

- SAMHSA Welcome
- Brief Overview of Year 3 TA Products
- Deeper Dive into
  - Core Elements of Cognitive Behavioral Therapy for Psychosis
  - Issues in the Treatment of Affective Psychoses
  - Integration of these Two Topics
- Q and A
Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).
Reminder: SAMHSA First Episode Psychosis (FEP) Technical Assistance Materials from FY 2015

• Snapshot of State Plans
• Resource Document: Inventory and Environmental Scan of Evidence Based Practices for Treating Persons in Early Stages of Serious Mental Disorders (currently being updated for 2016)
• Information Guide: Steps and Decision Points in Starting an Early Psychosis Program
• Web-Based Tutorial: Early Intervention in Psychosis: A Primer
• Fact Sheet: Building upon Existing Programs and Services to Meet the Needs of Persons with First Episode Psychosis (FEP)
• Issue Brief: Supported Education for Persons Experiencing a First Episode of Psychosis
• Manual: Peer Involvement & Leadership in Early Psychosis Programs
• Fact Sheet: Implementation of Coordinated Specialty Services for First Episode Psychosis in Rural and Frontier Communities

(available on-line at: http://www.nasmhpd.org/content/information-providers)
Reminder: SAMHSA First Episode Psychosis (FEP) Technical Assistance Materials from FY 2016

- Snapshot of State Plans
- **Fact Sheet**: Supporting Student Success in Higher Education Beyond the Clinic
- **Brochure**: Optimizing Medication Management
- **Brochure**: Some Basic Principles for Reducing Mental Health Medicine
- **Policy Brief**: Why Specialty Early Intervention Programs are a Smart Investment
- **Tool Kits**: Campus Staff and Administrators/Students and Families
- **Issue Brief**: Age and Developmental Considerations in Early Psychosis
- **Issue Brief**: What Comes After Early Intervention
- **Information Guide**: Use of Performance Measures in Early Intervention Programs
- **Web Based Course**: Family Primer on Psychosis

(available on-line at: [http://www.nasmhpd.org/content-information-providers](http://www.nasmhpd.org/content-information-providers))
2017 Products

Available at
http://www.nasmhpd.org/content/information-providers
Snapshot of State Plans

This information guide provides an overview of state activities related to the set aside, including funding information, a general overview of the state activities, level of program implementation, and specific CSC programs offered in the state for each state, territory, and the District of Columbia.
In 2017, states reported 261 CSC programs (251 funded by the MHBG set-aside and 10 that had other funding).

<table>
<thead>
<tr>
<th>FEP Treatment Program Implementation Phase</th>
<th>Receiving Set Aside Funds</th>
<th>Total Number of Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration</td>
<td>4 programs</td>
<td>4 programs</td>
</tr>
<tr>
<td>Installation</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Implementation</td>
<td>141</td>
<td>144</td>
</tr>
<tr>
<td>Program Sustainability</td>
<td>73</td>
<td>80</td>
</tr>
<tr>
<td>Total</td>
<td>251</td>
<td>261</td>
</tr>
</tbody>
</table>
Locations of Set-Aside Supported FEP Treatment Programs (CSC only)

First Episode Psychosis Treatment Programs

Legend
- Receives Set-Aside Funding
- Does Not Receive Set-Aside Funding

NOTE: This map only includes programs from states that have provided program addresses or locations. Some locations in California are mapped at the county level and do not show the exact location.

Aug. 2017
Fact Sheet: Cognitive Behavioral Therapy for Psychosis (CBTp)

Describes the key features of the evidence-based practice CBTp, the five phases on the service, its use in early psychosis along with a case study, and the training requirements for provider certification.
This brief provides information about accurately diagnosing substance-induced psychotic disorder, which can have similar symptoms as FEP, to ensure that services are tailored appropriately.
This brief provides several adaptations and recommendations that CSC teams may consider to enhance the effectiveness of the CSC model for individuals with affective psychosis and/or substance use disorders.
This tutorial is designed for clinicians and providers working in early psychosis programs. It includes nine characters based on dozens of in-depth interviews with clients, family members, and providers to increase provider awareness of and ability to respond to diverse stakeholder perspectives on early psychosis, including those from underrepresented socioeconomic, racial/ethnic, and cultural minority groups.
This brochure serves as a guide for individuals and their families who are experiencing psychosis for the first time. It makes recommendations on maintaining optimal physical health, which has implications for mental health.
The aim of this issue brief is to educate criminal justice professionals about FEP and the importance of early intervention; inform them of the availability of CSC models in the community; and to highlight opportunities for detection, diversion, and intervention.
Information Brief: Outreach for First Episode Psychosis

This guide provides a series of tailored strategies for conducting outreach and engagement at varying levels of the system providing these services, including state-level outreach, and strategies for providers.
This manual provides background material, methods, and case examples to implement community outreach and education.
This brief attempts to better understand the stigma experienced by individuals with FEP in contrast with those experiencing more chronic mental illnesses, and offers a series of proposals for addressing stigma for FEP.
This issue brief provides an overview of the literature available on DUP, an examination of different DUP measures available, and considerations when implementing these measures in community mental health settings.
This brief provides recommendations for best practices for addressing workforce challenges specific to CSC programs.
This information brief aims to help states and providers better understand how Medicaid can be used to develop more sustainable financing models that support CSC programs for FEP.
Webinars

- New Resource Materials on Addressing First Episode Psychosis: Product Overview
- Incorporating Peer Workers into Coordinated Specialty Care Programs
- Epidemiology of First Episode Psychosis in Large Integrated Healthcare Systems
- Outcome Measurement in First Episode Programming: Insights from the National Evaluation of Coordinated Specialty Care and the NIMH EPINET
- Issues in Accurate Diagnosis for Programs Serving Individuals with First Episode Psychosis
- Issues Associated with the Measurement of Untreated Psychosis
First Episode Psychosis Resources: Focus on Effective Treatment Options

Dr. Iruma Bello, PhD
Dr. Kate Hardy, Clin.Psych.D
Objectives

• Provide an overview of Coordinated Specialty Care (CSC)
• Review the delivery of CBTp within CSC
• Discuss strategies for treating affective psychosis within CSC programs
• Review CBT strategies for treating affective psychosis
• Discuss strategies for training the workforce
Early Intervention Services

Coordinated Specialty Care Components

- Team Leadership
- Case Management
- Supported Education and Employment
- Psychotherapy
- Family Education and Support
- Pharmacotherapy
- Primary Care Coordination
NIMH RAISE Projects

Randomized clinical trial

- John Kane
- Nina Schooler
- Delbert Robinson

Implementation study

- Lisa Dixon
- Susan Essock
- Jeffery Lieberman
- Howard Goldman
Cognitive Behavioral Therapy for psychosis

Kate Hardy, Clin.Psych.D
What is CBT?

• How you think leads to changes in how you feel and what you do
• Thinking includes how you think about:
  – Yourself
  – The world
  – Other people
• Here and now focus though draws upon past experiences to explain how beliefs are formed
Session Structure

- Review of the week & mood/symptom check
- Review previous session
- Agenda setting
- Homework review
- Discuss agenda items
- Homework assignment
- Final summary and feedback
<table>
<thead>
<tr>
<th>Principles</th>
<th>CBT for depression/anxiety</th>
<th>CBT for psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basis in a cognitive model</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Formulation driven</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Structured</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Shared problem list and goal development</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Educational</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Uses guided discovery</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Homework</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Time limited</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Relapse prevention</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
History of CBTp

• Largely overlooked as an intervention for psychosis
• Prominence of biological/medical models
• Studies in the 80’s that reported talking therapies as damaging to people with psychosis
• Long held assumption psychosis lies outside of realm of ‘normal psychological functioning’
Psychosis exists on a continuum

- Stress
- Drugs
- Trauma
- Life experiences
- Sleep deprivation
CBT for psychosis

Focus is on **reducing the distress** caused by **positive symptoms** including hallucinations and unusual thoughts and **increasing functioning**

**Thoughts**
- Interpretation of the event that causes distress rather than the event itself
- Need to check the accuracy of the interpretation

**Behaviors**
- How are current behaviors maintaining the problem?
- Need to check the helpfulness of current behaviors
Other target areas:

- Depression and anxiety
- Past traumatic experiences
- Social skills
- Negative symptoms
- Problem solving and decision making
- Developing coping skills
- Wellness planning
Evidence Base for CBTp

- Improved positive and negative symptoms and functioning (Wykes et al., 2008; Burns et al., 2014, Turner et al., 2014)
- Prevent, or delay, transition to full psychosis (Stafford et al., 2013)
- Recommended as adjunctive treatment to medication management (Dixon et al., 2010; NICE 2014)
CBTp: a word of caution

• Complaints of publication bias and ‘overselling’ (Jauhar et al. 2014)

• Poor therapeutic alliance predictive of poor outcomes (Goldsmith et al, 2015)
  • CBTp should only be delivered when good therapeutic alliance is possible
Why provide CBTp for early psychosis?

<table>
<thead>
<tr>
<th>Early Intervention Principles *</th>
<th>CBTp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide interventions with demonstrated efficacy</td>
<td>Evidence Based</td>
</tr>
<tr>
<td>Provide services that actively partner with young people (Shared Decision Making)</td>
<td>Client generated problem list</td>
</tr>
<tr>
<td></td>
<td>Collaborative approach (the “collaborative fence”)</td>
</tr>
<tr>
<td></td>
<td>Development of shared understanding (formulation)</td>
</tr>
<tr>
<td>Challenge stigmatizing and discriminatory attitudes</td>
<td>Normalization</td>
</tr>
<tr>
<td>Generate optimism and expectation of positive outcomes and recovery</td>
<td>Problem list and goals</td>
</tr>
<tr>
<td></td>
<td>Focus on functional recovery (not symptom reduction)</td>
</tr>
<tr>
<td></td>
<td>Development of skills and tools to support and maintain recovery</td>
</tr>
<tr>
<td></td>
<td>Wellness Planning</td>
</tr>
<tr>
<td>Respect the right to recovery and social inclusion</td>
<td></td>
</tr>
<tr>
<td>Culturally Sensitive Services</td>
<td>Individualized formulation</td>
</tr>
<tr>
<td>Respect the right for family &amp; friends to participate in treatment</td>
<td>Include family and important support people in wellness planning</td>
</tr>
</tbody>
</table>

*based on values and vision described in Bertolote and McGorry (2006)
Essential Components of CBTp

1. Collaborative development of shared formulation
   • Informs how symptoms developed and are maintained

2. Normalization of psychosis
   • Address stigma often associated with psychosis

3. Acceptance of psychotic symptoms
   • To ensure focus is on reduction of distress associated with symptoms and not removal

(Brabban et al., 2016)
Phases of CBTp

- Engagement and Befriending
  - Development of therapeutic relationship
  - Normalizing
  - Goal setting

- Assessment of Experiences
  - Collaborative exploration of experiences
  - “Sitting on the collaborative fence”

- Formulation
  - Shared understanding of links between thoughts, emotions, behaviors
  - Links between early experiences, core beliefs, and symptoms
What happened
Hears a voice

How I make sense of it
I am possessed
I need to be exorcised

Beliefs about yourself and others
I’m bad.
I’m different

Life experiences
Father died
Mom overwhelmed and critical
Difficulties academically and socially
Raised Catholic

What do you do when this happens?
Talks to voices
Researches demons and exorcism online

How does it make you feel?
Scared
Anxious

(Morrison, 2001)
Phases of CBTp Cont.

- Application of intervention
  - *Formulation informs intervention*
  - *Cognitive and Behavioral interventions to support goal attainment*

- Consolidation of skills
  - *Practice skills between sessions*
  - *Develop plan for sustainable use of skills*
Treating Affective Psychosis Within CSC Programs

Iruma Bello, Ph.D.
Affective Psychosis

- Non-affective psychosis: schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, psychosis NOS, or delusional disorder
- Affective psychosis: symptoms of psychosis that are present with mood episodes
  - Major depression with psychotic features
  - Bipolar Disorders
Goal: reduce DUP and provide specialized early intervention services to improve outcomes and functioning

- Use of medications
- Assertive outreach and engagement
- Focus on suicidality
- CBT strategies to promote resiliency and relapse prevention
- Monitoring health-related factors
- Flexible, developmentally appropriate, person-centered care
Areas for adaptation

- Prescribing practices
- Engagement
- Cognitive behavioral strategies
- Cognition
- Work with families
Prescribing

- **Bipolar Disorder (not exhaustive):** (Connolly & Thase, 2011)
  - Mania - treated first with lithium, divalproex or an atypical antipsychotic
  - Mixed episodes - treated with divalproex or an atypical antipsychotic
  - Depressive episodes - treated first with quetiapine, olanzapine/fluoxetine combination, or lamotrigine
Prescribing cont’d

• Depression with psychotic features (Wijkstra, et. al., 2015)
  • antidepressant and antipsychotic is more effective than antidepressant monotherapy
  • more effective than antipsychotic monotherapy
  • more effective than placebo.
Engagement

• Consider symptom-related barriers to developing a therapeutic alliance:
  • Extended periods of recovery between mood episodes
  • Mania perceived as welcome respite from depression
• Providers need to be flexible in their use of engagement strategies across illness phases
CBT Strategies

• Special attention paid to the cyclical nature of the illness course

• Techniques:
  • Mood monitoring
  • Focus on sleep hygiene and circadian rhythms
  • Coping skills tailored to activity level changes across mood episodes
  • Strategies for effective decision making during manic episodes that target promiscuity, impulsivity and increased substance use
Cognition

• Cognitive deficits in bipolar disorder become more prevalent and severe as people experience more affective episodes (Burdick et al., 2015)
• Cognitive deficits can be present during periods of depression, mania and/or euthymia
• Incorporating a cognitive remediation program can be beneficial (Veeh, Kopf, Kittel-Schneider, Deckert, & Reif, 2017)
  • 12 sessions delivered in 90 minutes
  • Skills group and computer-assisted program
Working with Families

- Research Findings:
  - Increased expressed emotion associated with higher relapse in mood disorders (Miklowitz, Goldstein & Nuechterlein, 1995)
  - Low maternal warmth associated with a 4.1X increased likelihood of relapse
  - Higher rates of perceived stigmatization in their families compared to in the workplace (Geller, Craney, & Bolhofner, 2002; Morselli & Elgie, 2003)
  - 64.8% reported rate of family history of mental illness and 45% rate of a current family member diagnosed with bipolar disorder (Hirschfeld, Lewis, & Vornik, 2003; Morselli & Elgie, 2003)
Working with Families

- Bipolar Disorder: A Family-Focused Treatment Approach (Miklowitz et. al., 2008)

- Teach families
  - “how to express positive feelings”
  - “active listening”
  - “making positive requests for change”
  - “expressing negative feelings about specific behaviors”
  - essentials of mood monitoring
Special Considerations

- Episodic nature of mood disorders requires tailoring the interventions.
- Individuals with affective psychosis may present with periods of euthymia when functional recovery is attained.
- Across time, individuals may show better illness course than those individuals diagnosed with schizophrenia.
Conclusions

• CSC programs have many of the required treatments for working with affective psychosis.
• Needed adaptations: prescribing practices, engagement, cognitive behavioral strategies, and work with families.
• Overlap between affective and non-affective psychotic presentations suggests that these adolescents and young adults can derive significant benefits from receiving early-intervention services.
CBT strategies for treating affective psychosis
## Treatment Similarities

- **Formulation-based CBT**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I</td>
<td>reduce risk and manage behavioral issues during the acute phase</td>
</tr>
<tr>
<td>Phase II</td>
<td>cognitive restructuring and behavioral experiments during the intermediate phase</td>
</tr>
<tr>
<td>Phase III</td>
<td>focus on relapse prevention during the final phase</td>
</tr>
</tbody>
</table>
Case Formulation

TRIGGER
Bored, frustrated by people

CHANGE IN INTERNAL STATE
HIGH
Nagging voice

LOW
"I'm not doing it"

Ascent Behaviour
Do things quickly
Not satisfied
Not fulfilled

Viewed as having extreme personal meaning
Plays on mind
Ruminates

Descent behaviour
Not worth it
Vegetate
Watch TV
Withdraw

Balance Behaviours
Stop and think
Take time and assess things. Implement intervention
i.e. go for a walk
## Treatment Differences

<table>
<thead>
<tr>
<th>Non-Affective Psychosis</th>
<th>Affective Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing environmental stimulation to involve individuals in their surroundings and increase their feelings of connectedness regardless of symptomatology</td>
<td>Only appropriate during periods of depression; mania requires reducing environmental stimuli</td>
</tr>
<tr>
<td>Cognitive restructuring implemented similarly throughout treatment</td>
<td>Cognitive restructuring modified according to varying mood episode</td>
</tr>
<tr>
<td>Less focus on specific negative life events</td>
<td>Focusing on association between negative life events as precipitants to mood episodes</td>
</tr>
<tr>
<td>Illness more linear and consistent</td>
<td>Focus on cyclical nature of illness</td>
</tr>
</tbody>
</table>
Techniques

• Mood monitoring
• Focus on sleep hygiene and circadian rhythms
• Coping skills tailored to activity level changes across mood episodes
• Strategies for effective decision making during manic episodes that target promiscuity, impulsivity and increased substance use
Mood Monitoring

- Highlight associations between mood patterns and response to treatment
- Track daily mood fluctuations to understand illness trajectory and learn to anticipate upcoming episodes
  - Identify life events, distressing thoughts
- Can be effectively done during a therapy session
• Mood monitoring chart

Things that made me experience particularly high or low moods during these two weeks were:

- [List of events or factors]
- [List of events or factors]
- [List of events or factors]
Sleep Cycles

- Interpersonal and social rhythm therapy (IPSRT) found to significantly decrease relapses of mood episodes by regulating sleep cycles and daily routines (Goldstein et al., 2014)
- Help the individual identify and seek out others who can help maintain a stable routine and sleep schedule during a period of time that is intrinsically defined by instability, change, and growth
  - avoiding daytime naps, avoiding stimulants, creating a calm and non-stimulating sleeping environment, promoting exercise
Activity Level

- Focus on social skills, problem solving, and communication skills to help adolescents navigate complex relationships and interpersonal conflicts effectively.

- Coping skills for managing different activity levels and responsibilities that may interact with manic or depressive mood episodes.
Making Decisions during Mania

Mania associated with impulsive spending, sexual promiscuity, and increased substance use

- delay of major life decision by at least 48 hours
- keep a running account of ideas that can be revisited later
- encourage avoidance of substances (caffeine, drugs and alcohol)
- encourage avoidance of risky situations and model using decisional balance tools
- encourage avoidance of giving away possessions until mood stabilizes
- practice asking the opinion of two trusted friends before starting new projects
- identify calming situations to be used for coping with symptoms and help reducing stimulation
Training Considerations

- Establish competency for formulating and conceptualizing affective and non-affective psychosis
- Submitting tapes for review of sessions that are focused on targeting mood episodes and psychosis
- Demonstrating skills addressing the effective components of the treatment
Questions?

Thank you!