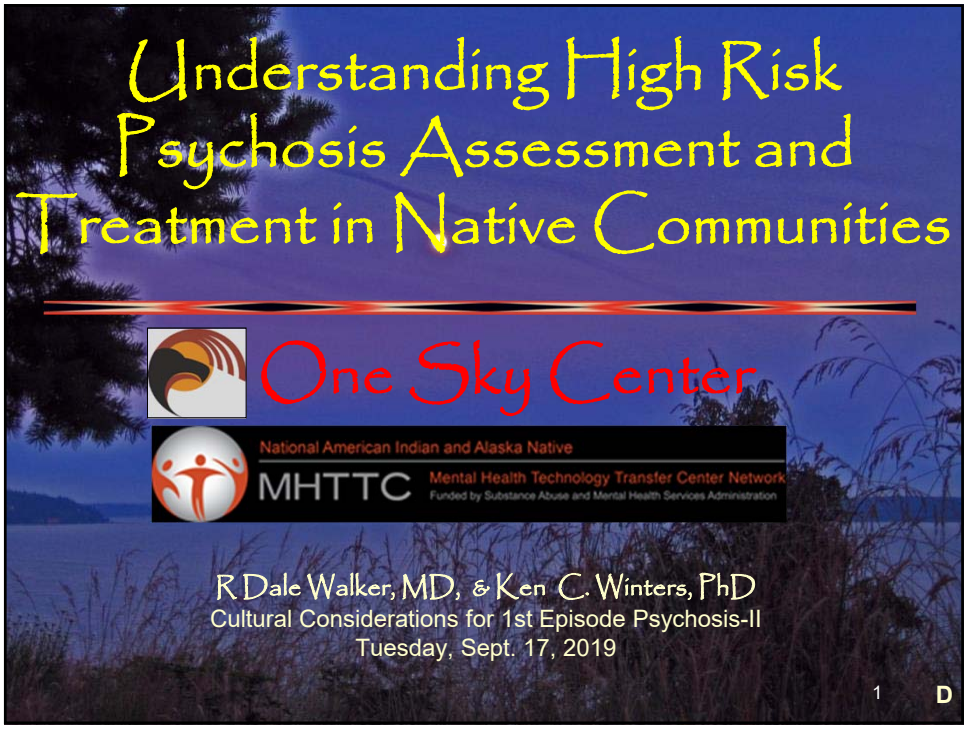
Understanding High Risk Psychosis Assessment and Treatment in Native Communities
One Sky Center
National American Indian and Alaska Native
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration
R Dale Walker, MD, & Ken C. Winters, PhD
Cultural Considerations for 1st Episode Psychosis-II
Tuesday, Sept. 17, 2019
1
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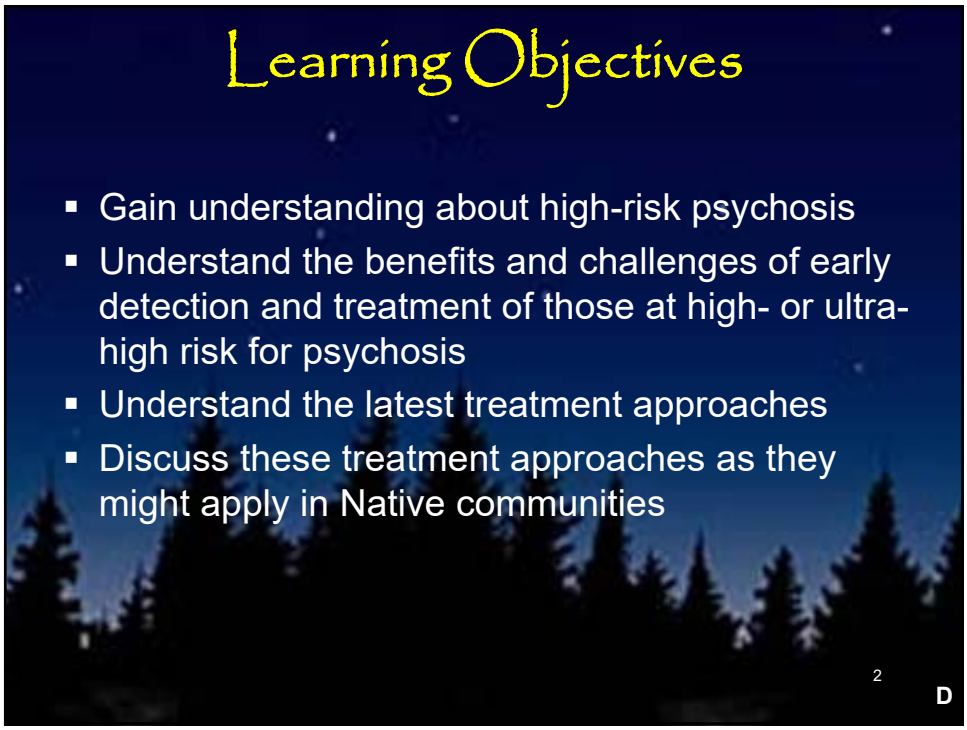
Learning Objectives
Gain understanding about high-risk psychosis
Understand the benefits and challenges of early detection and treatment of those at high- or ultra-high risk for psychosis
Understand the latest treatment approaches
Discuss these treatment approaches as they might apply in Native communities
2
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2

Risk Factors of Psychosis

Can young people be reliably identified who are at high and imminent risk of developing a first episode of psychosis?

1. Current research suggests that a combination of biological and environmental factors create a situation where a person is vulnerable to, or at a greater risk of, developing psychotic symptoms.
2. A number of brain chemicals, including dopamine and serotonin, may play a role in how psychosis develops.
3. A stressful event may trigger psychotic symptoms in a person who is vulnerable.
4. Risk factors linked to psychosis are far from definitive; caution is recommended to avoid false positives.
5. It is important for the individual to have a thorough medical and psychological assessment to rule out any physical illness that may be the cause of the psychosis.

3

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3

Though it is Unknown, the Prevalence and Incidence of High Risk Psychosis is Probably Similar or Higher to the General Population Youth

Running Strong for American Indian Youth 4

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4

Native Health Morbidity: Disparity

1. Alcoholism 6X
2. Tuberculosis 6X
3. Diabetes 3.5 X
4. Accidents 3X
5. Poverty 3x
6. Depression 3x
7. Suicide 2x
8. Violence?
9. Trauma?

1. Same disorders as general population
2. Greater prevalence
3. Greater severity
4. Much less access to Tx
5. Cultural relevance more challenging
6. Social context disintegrated

5 D

5

What is Psychosis?

- Severe and persistent disturbances in thinking, mood and behavior that very seriously impact the daily functioning of the person

- Presence of one or more:
  - Delusions (fixed false beliefs)
  - Hallucinations (Auditory most common, but can be with any of the senses)
  - Disorganized speech (sometimes to incoherence)
  - Disorganized behavior
  - Catatonia

1. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml
2. https://medicine.yale.edu/psychiatry/step/psychosis/firstepisode.aspx

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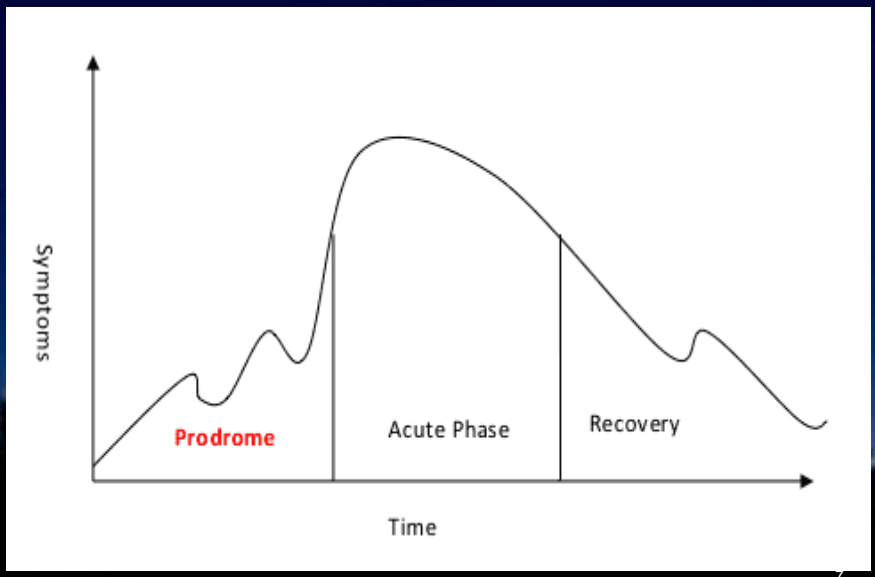
Three Phases of Psychosis



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Prodromal Phase (subclinical, early signs)

- These early signs may be subtle and hardly noticeable. Common signs (which vary among individuals in this phase)
  1. reduced concentration
  2. decreased motivation
  3. withdrawal from friends and family
  4. sleep problems
  5. deterioration in functioning
  6. unusual beliefs/magical thinking

1. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml
2. https://medicine.yale.edu/psychiatry/step/psychosis/firstepisode.aspx

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Acute Phase (Disorder is Present)

- Symptoms of this phase (which may vary among individuals)
  1. confused thinking
  2. false beliefs
  3. hallucinations
  4. changed feelings
  5. changed behavior

1. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml
2. https://medicine.yale.edu/psychiatry/step/psychosis/firstepisode.aspx

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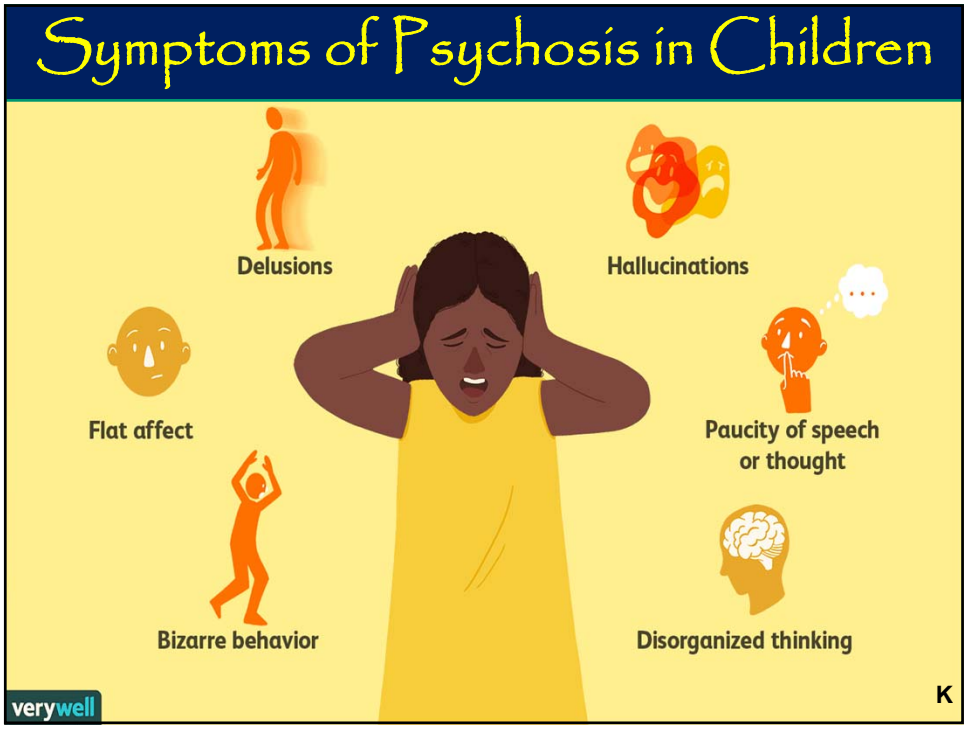
Symptoms of Psychosis in Children
Delusions
Hallucinations
Flat affect
Paucity of speech or thought
Bizarre behavior
Disorganized thinking
verywell
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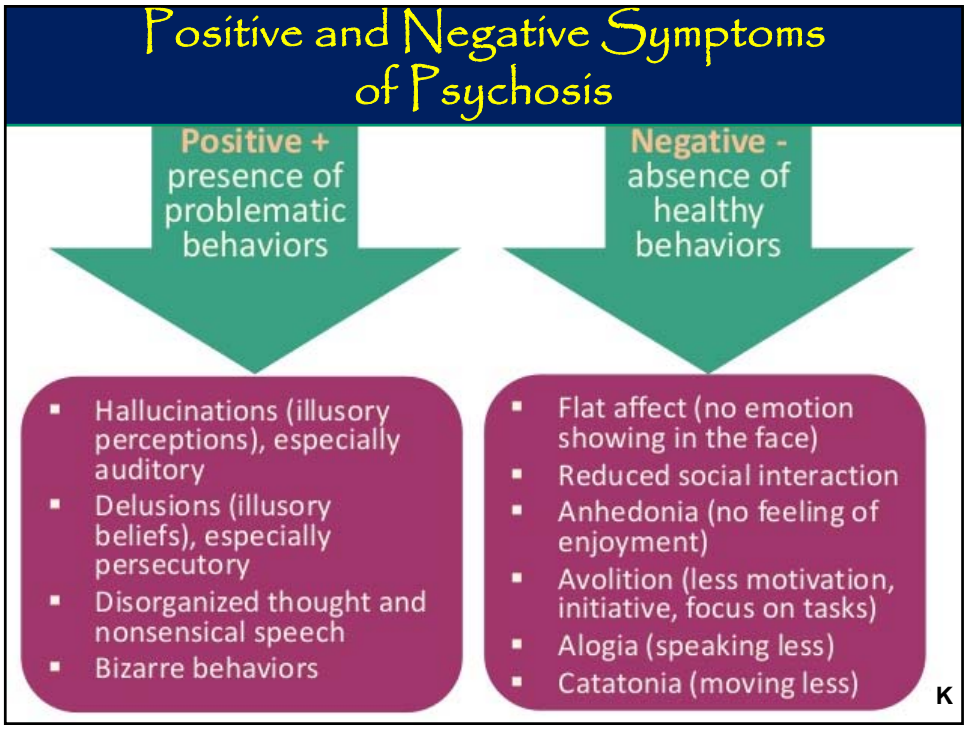
Positive and Negative Symptoms of Psychosis
Positive + presence of problematic behaviors
Negative - absence of healthy behaviors
Hallucinations (illusory perceptions), especially auditory
Delusions (illusory beliefs), especially persecutory
Disorganized thought and nonsensical speech
Bizarre behaviors
Flat affect (no emotion showing in the face)
Reduced social interaction
Anhedonia (no feeling of enjoyment)
Avolition (less motivation, initiative, focus on tasks)
Alogia (speaking less)
Catatonia (moving less)
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13

Recovery (Post Disorder)

- Effective treatment can lead most individuals to recover from their first episode of psychosis, and many without a return of severe symptoms
- Treatment works!

1. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml
2. https://medicine.yale.edu/psychiatry/step/psychosis/firstepisode.aspx

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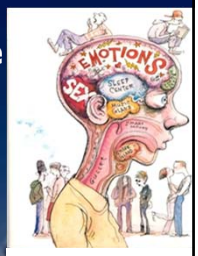
15

The "Gray" Nature of Adolescent Behavior

- **Normal adolescent behavior can be confused with early symptoms of psychosis**
  - **Some common features of adolescence**
    - ✓ **Inattention**
    - ✓ **Repetitive or distressing thoughts**
    - ✓ **Difficulties thinking clearly**
    - ✓ **Unpredictable and disruptive behavior**
    - ✓ **Rapid changes in mood**
    - ✓ **Functioning issues in social and academic settings**



Source: US News & World Report, 2005

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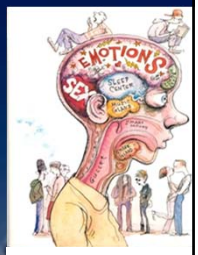
16

The "Gray" Nature of Adolescent Behavior

- **A challenge in measuring and detecting HR criteria: Normal adolescent behaviors can mimic these criteria of early psychosis**



Source: US News & World Report, 2005

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The "Gray" Nature of Adolescent Behavior

- **Distinguishing normalcy from ER criteria**
  - ✓ **Does the behavior meaningfully disrupt social and role functioning?**
  - ✓ **Are the behaviors persistent?**
  - ✓ **Do the behaviors cause distress to the individual and others?**
  - ✓ **Does context <u>not</u> explain or moderate the behavior?**

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This is What We See in Progression of Untreated Psychosis
Disruption of Critical Developmental Period
Loss of protective factors for Work and Support
Disability Welfare
Patrick McGorry Australia Univ. of Melbourne
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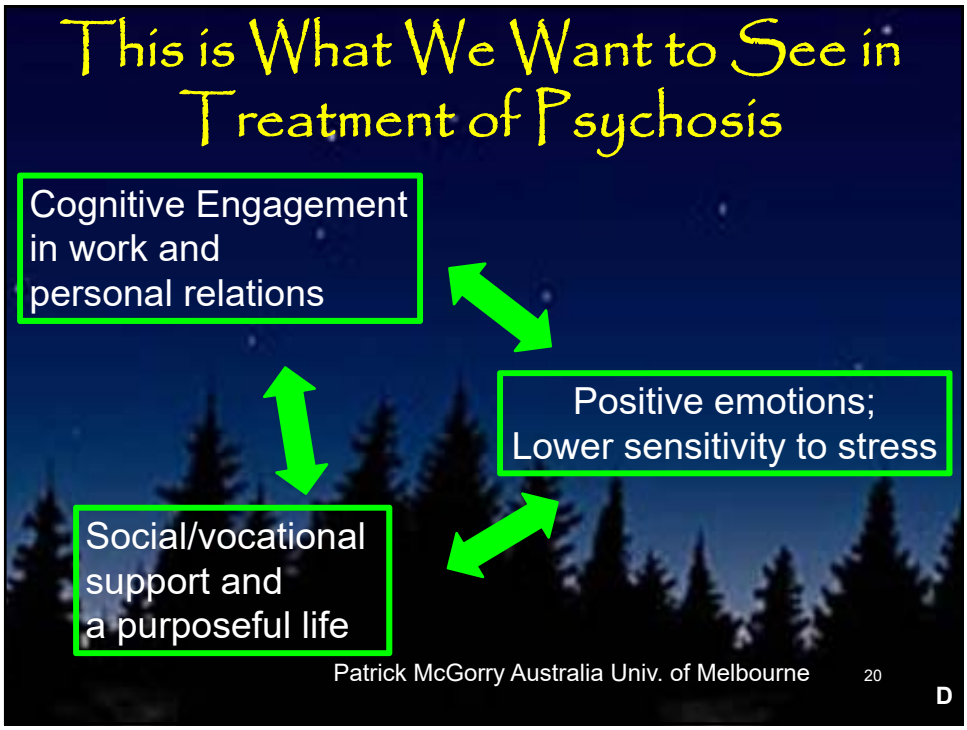
This is What We Want to See in Treatment of Psychosis
Cognitive Engagement in work and personal relations
Positive emotions; Lower sensitivity to stress
Social/vocational support and a purposeful life
Patrick McGorry Australia Univ. of Melbourne
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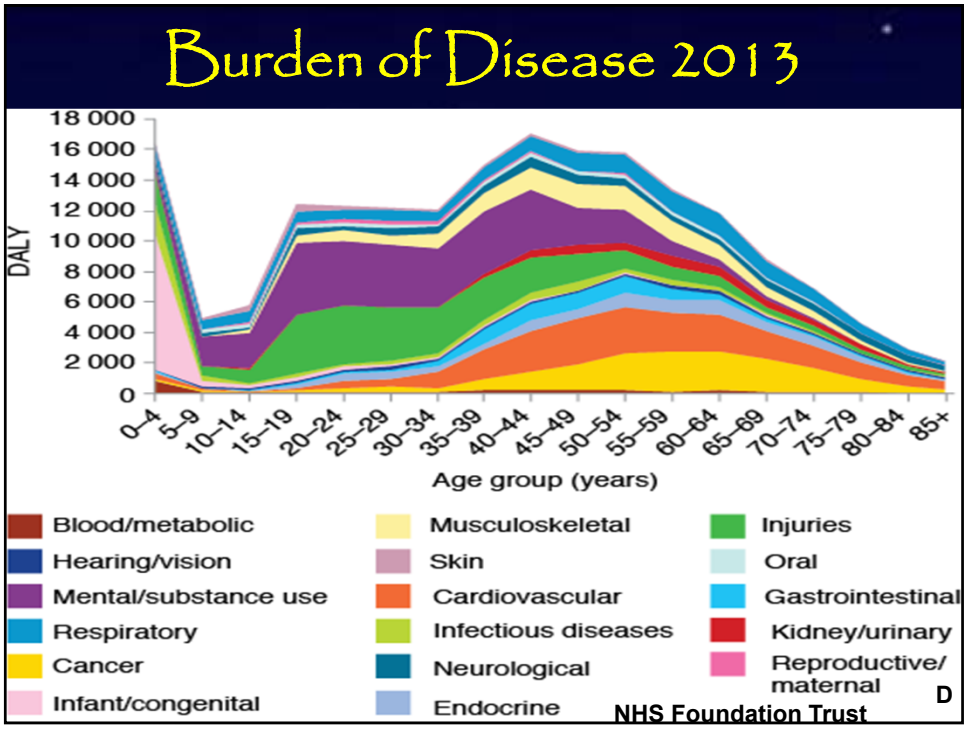
Burden of Disease 2013
DALY
18 000
16 000
14 000
12 000
10 000
8 000
6 000
4 000
2 000
0
0–4
5–9
10–14
15–19
20–24
25–29
30–34
35–39
40–44
45–49
50–54
55–59
60–64
65–69
70–74
75–79
80–84
85+
Age group (years)
Blood/metabolic
Hearing/vision
Mental/substance use
Respiratory
Cancer
Infant/congenital
Musculoskeletal
Skin
Cardiovascular
Infectious diseases
Neurological
Endocrine
Injuries
Oral
Gastrointestinal
Kidney/urinary
Reproductive/ maternal
NHS Foundation Trust
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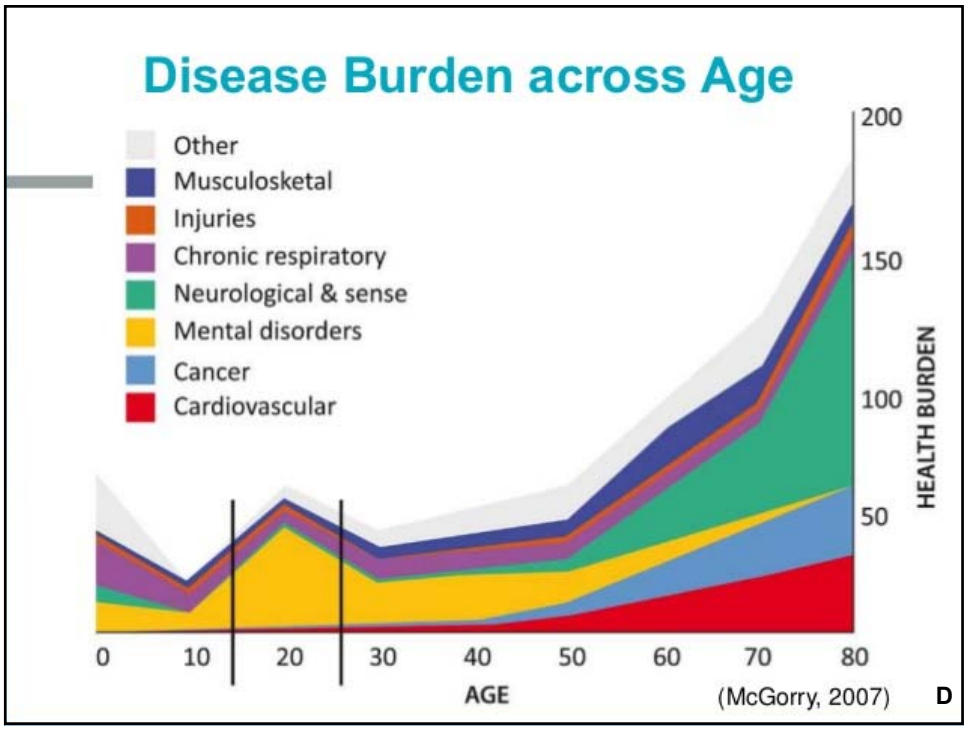
Disease Burden across Age
Other
Musculosketal
Injuries
Chronic respiratory
Neurological & sense
Mental disorders
Cancer
Cardiovascular
200
150
100
50
HEALTH BURDEN
0
10
20
30
40
50
60
70
80
AGE
(McGorry, 2007)
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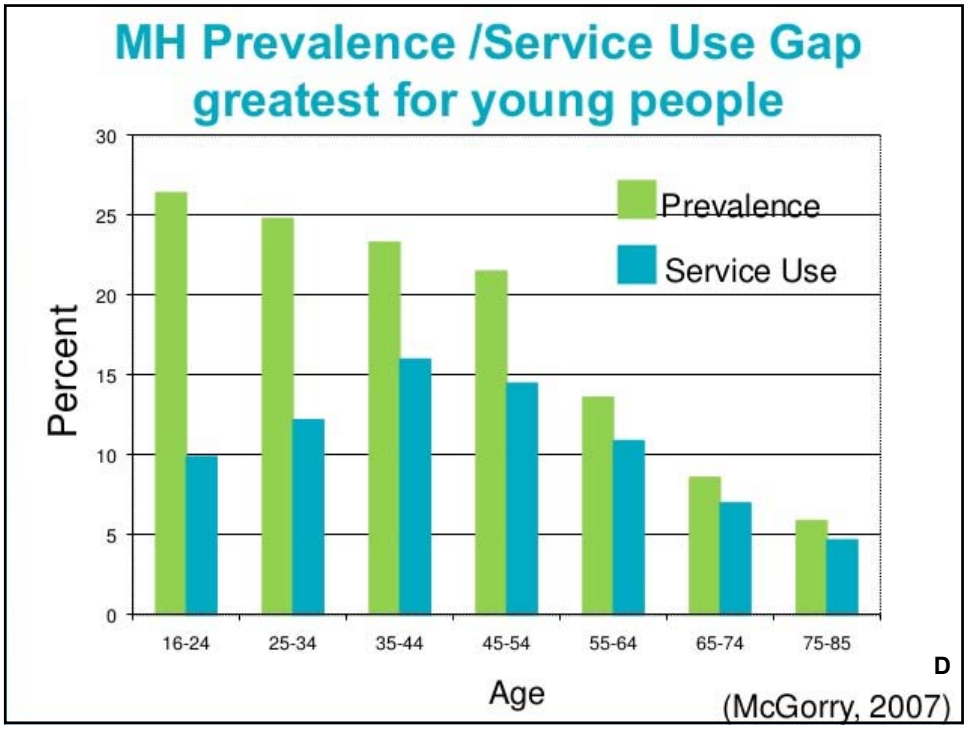
MH Prevalence /Service Use Gap greatest for young people
Prevalence
Service Use
Percent
30
25
20
15
10
5
0
16-24
25-34
35-44
45-54
55-64
65-74
75-85
Age
D
(McGorry, 2007)

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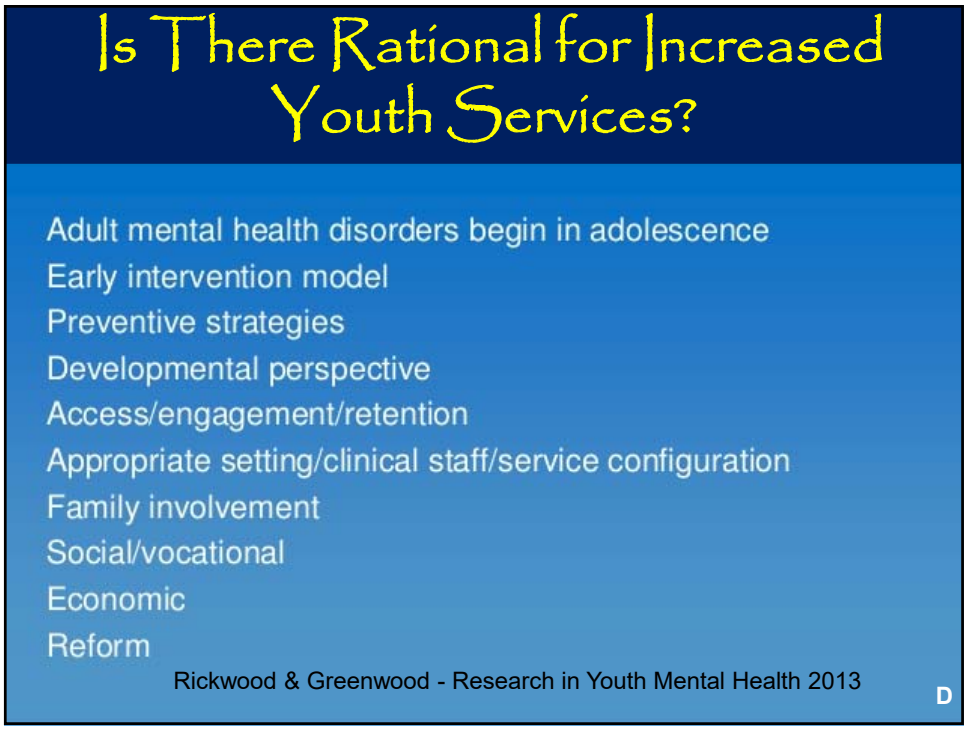
Is There Rational for Increased Youth Services?
Adult mental health disorders begin in adolescence
Early intervention model
Preventive strategies
Developmental perspective
Access/engagement/retention
Appropriate setting/clinical staff/service configuration
Family involvement
Social/vocational
Economic
Reform
Rickwood & Greenwood - Research in Youth Mental Health 2013
D

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Is There Evidence for Youth Services?

Adult mental health disorders begin in adolescence – Insel 2005, Jones 2013

Early intervention – Mihalopoulos 2009, McGorry 2013

Preventive strategies – Yung 2013, Stallard 2013, Chanen 2013

Developmental perspective – Lamb 2013

Access/engagement/retention – Singh 2009

Appropriate setting/clinical staff/service configuration – McGorry 2009

Family involvement – Bebbington 2011

Social/vocational – Killackey 2010

Economic – Knapp & McCrone 2010 (2013)

Reform - ???

Rickwood & Greenwood - Research in Youth Mental Health 2013

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1. What is High-Risk or Ultra-High Risk for Psychosis?

- **Some individuals, by virtue of possessing several risk factors, are at high risk or ultra-high risk of developing a first episode psychosis.**
- **A first episode psychosis will occur among 15-30% of HR individuals within 12 months, and over 36% after 3 years.**
  - **These "transition rates" are several hundredfold above that of the general population**

1. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml
2. https://medicine.yale.edu/psychiatry/step/psychosis/firstepisode.aspx

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2. What is High-Risk or Ultra-High Risk for Psychosis?

- Main risk factors
  - ✓ Family history of psychosis
  - ✓ Several behavioral indices….
    - attenuated psychotic symptoms
    - widespread cognitive deficits
      - poor school performance
      - unusual thoughts (including high suspicions/paranoia)
    - low social functioning
    - substance abuse
    - overall functioning difficulties

Source: Fusar-Poli et al., 2013, *JAMA Psychiatry*

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3. What is High-Risk or Ultra-High Risk for Psychosis?

- Measuring risk factors – several structured and semi-structured interviews
  - Structured Interview for Prodromal Symptoms (SIPS)
  - Comprehensive Assessment of At-Risk Mental State (CAARMS)
  - Early Recognition Inventory for the Retrospective Assessment of the Onset of Schizophrenia (ERIraos)
  - Basel Screening Instrument for Psychosis (BSIP)

Source: Fusar-Poli et al., 2013, *JAMA Psychiatry*

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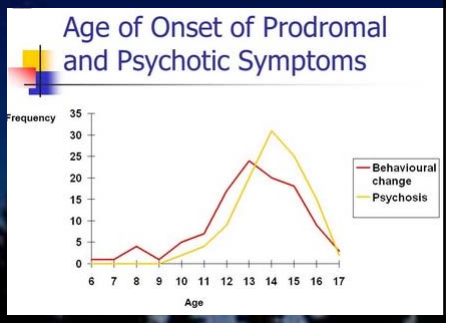
4. What is High-Risk or Ultra-High Risk for Psychosis?

- **Onset:**
  - ***HR signs*** **usually emerge in the teenager years**
  - ***Symptoms of psychosis*** **typically first begin in late adolescence and early adulthood**



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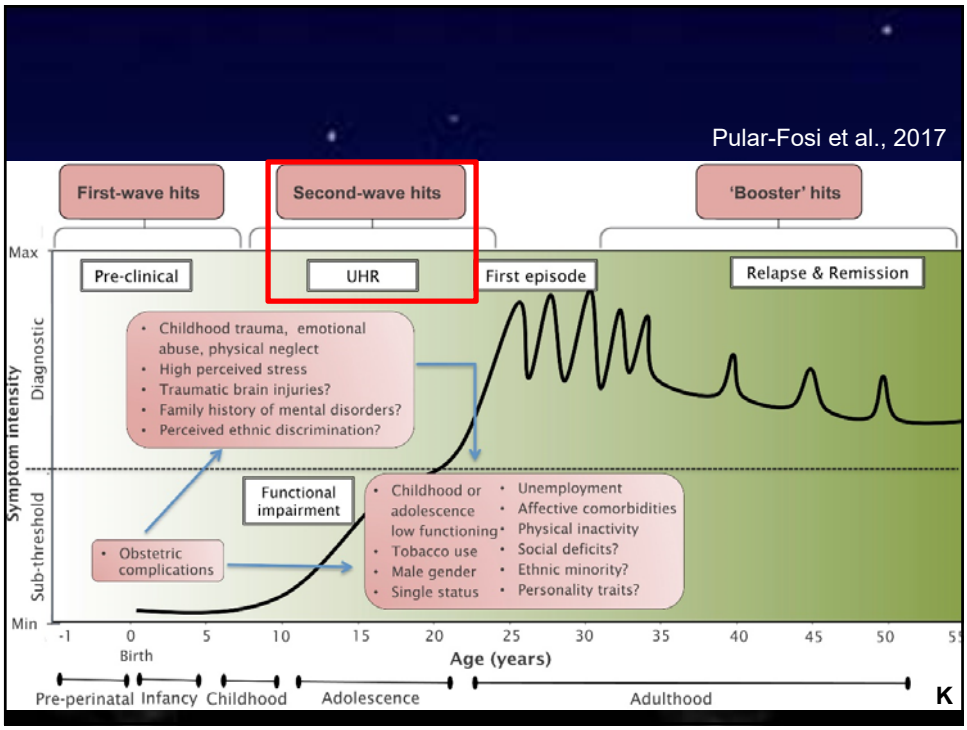

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Ultra High-Risk Criteria[a]

Group	Criteria
1: Attenuated positive psychotic symptoms	Presence of ≥1 of the following symptoms: ideas of reference, odd beliefs or magical thinking, perceptual disturbance, paranoid ideation, odd thinking and speech, odd behavior, and appearance Frequency of symptoms: at least several times a week Recency of symptoms: present within the past year Duration of symptoms: present for ≥1 wk and ≤5 y
2: Brief limited intermittent psychotic symptoms	Transient psychotic symptoms: presence of ≥1 of the following: ideas of reference, magical thinking, perceptual disturbance, paranoid ideation, and odd thinking or speech Duration of episode: <1 wk Frequency of symptoms: at least several times per week Symptoms resolve spontaneously Recency of symptoms: must have occurred within the past year
3: Trait and state risk factors	Schizotypal personality disorder in the identified individual or a first-degree relative with a psychotic disorder Significant decline in mental state or functioning (30% drop in GAF score), maintained for at least ≥1 mo and ≤5 y This decline in functioning must have occurred within the past year

[a] Ultra high-risk criteria: (1) must be aged between 15 and 30 years, (2) have been referred to a specialized service for help, and (3) meet the criteria for 1 or more of the 3 groups.

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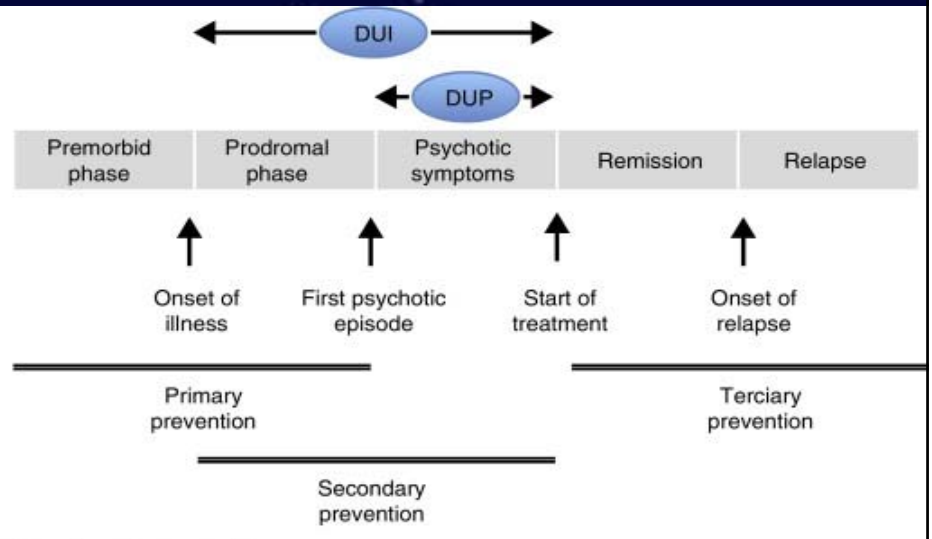
When Healthcare does not Follow the Evidence: The Case of the Lack of Early Intervention



DUI: Duration of untreated illness
DUP: Duration of untreated psychosis

Revista de Psiquiatría y Salud Mental
Volume 10, Issue 2, April–June 2017, Pages 78-86

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Traditional Diagnostic Approach Verses Continuous Measures

Raquel E. Gur. Springer International Publishing 3 April 2014 33

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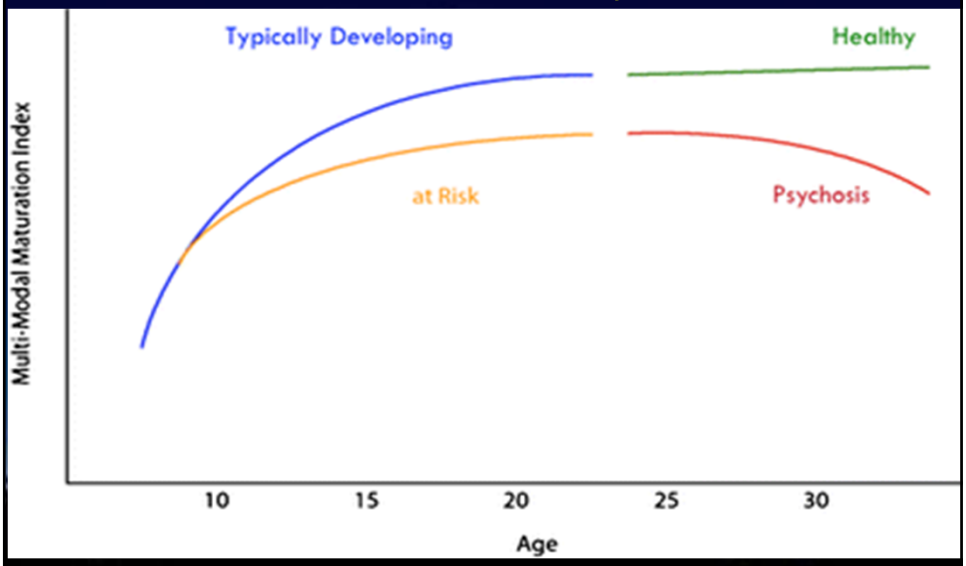
Developmental Trajectories



doi:10.1038/npjschz.2016.3; published online 9 March 2016 34

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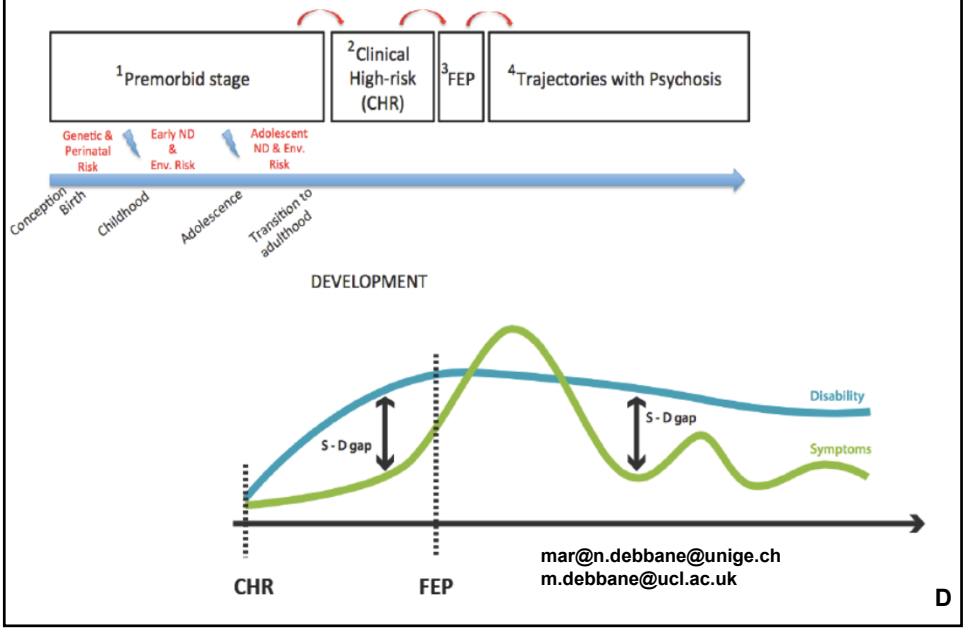
Symptom – Disability (S-D) Gap



mar@n.debbane@unige.ch
m.debbane@ucl.ac.uk

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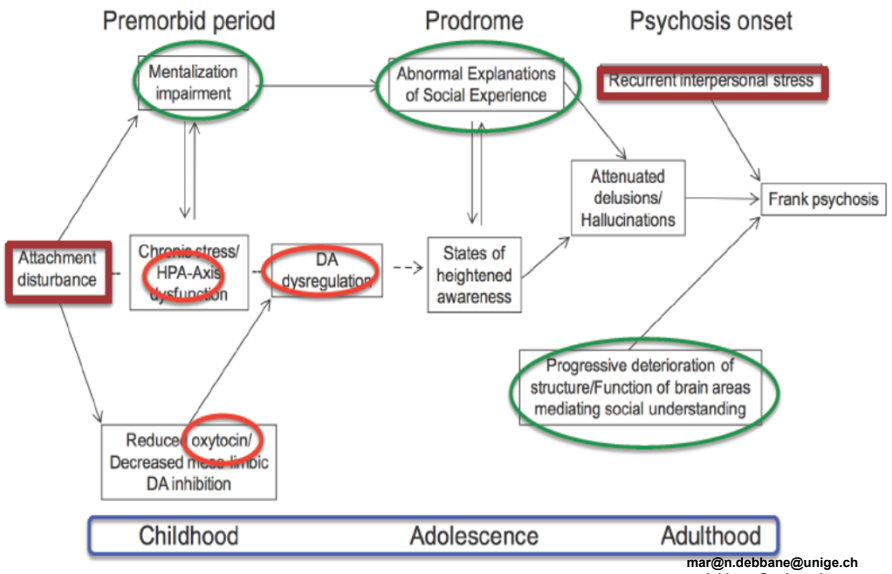
Psychosis Development



mar@n.debbane@unige.ch
m.debbane@ucl.ac.uk

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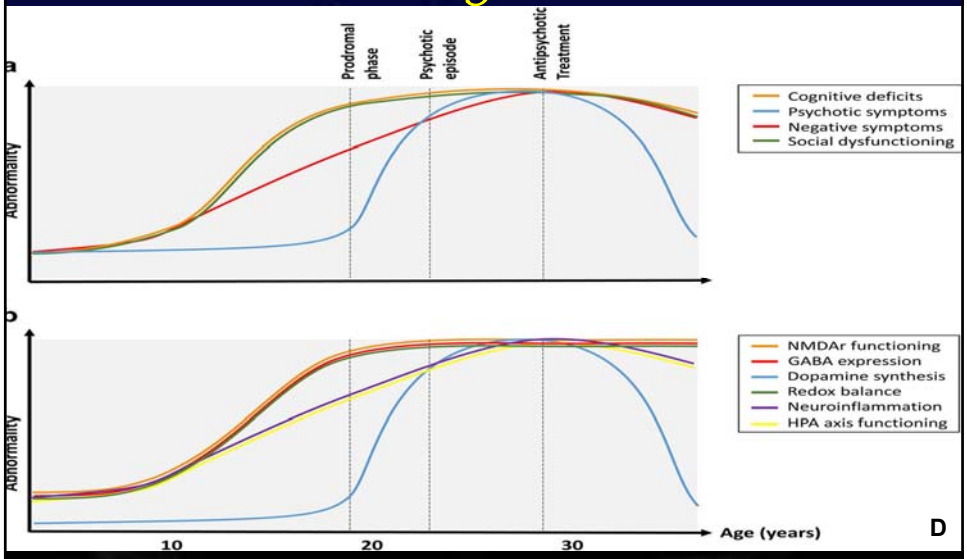
Early Interventions in Risk Groups for Psychosis



Schizophrenia (2016) 2, Article number: 16003; doi:10.1038/npjschz.2016.3; published online 9 March 2016

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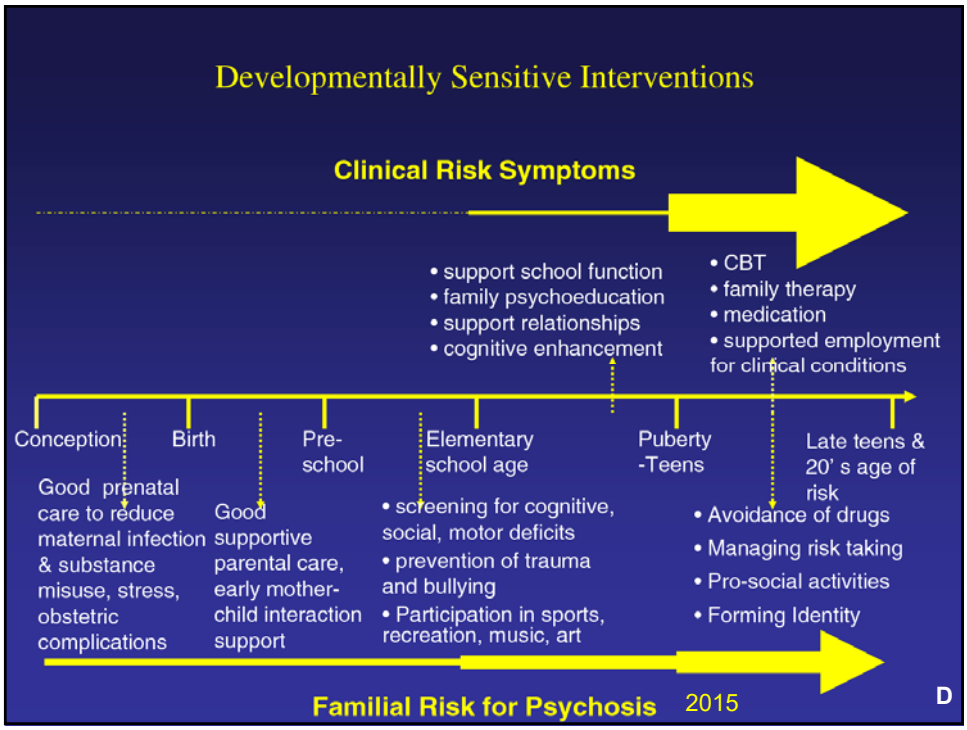

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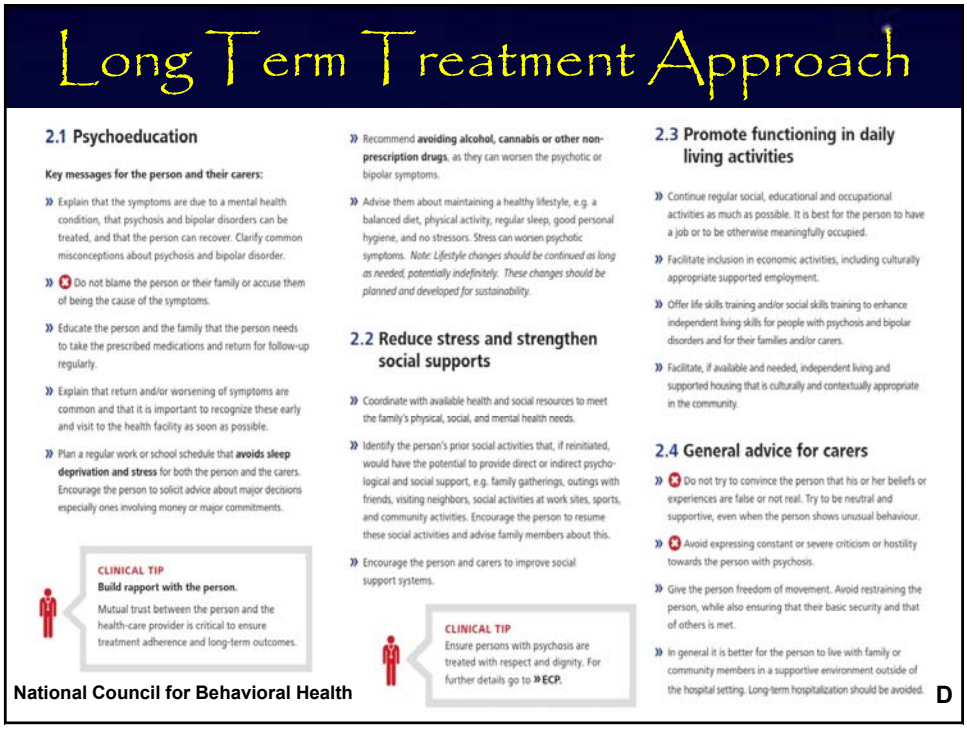
Long Term Treatment Approach



2.1 Psychoeducation

Key messages for the person and their carers:

- Explain that the symptoms are due to a mental health condition, that psychosis and bipolar disorders can be treated, and that the person can recover. Clarify common misconceptions about psychosis and bipolar disorder.
- Do not blame the person or their family or accuse them of being the cause of the symptoms.
- Educate the person and the family that the person needs to take the prescribed medications and return for follow-up regularly.
- Explain that return and/or worsening of symptoms are common and that it is important to recognize these early and visit to the health facility as soon as possible.
- Plan a regular work or school schedule that **avoids sleep deprivation and stress** for both the person and the carers. Encourage the person to solicit advice about major decisions especially ones involving money or major commitments.

CLINICAL TIP
Build rapport with the person.
Mutual trust between the person and the health-care provider is critical to ensure treatment adherence and long-term outcomes.

- Recommend **avoiding alcohol, cannabis or other non-prescription drugs**, as they can worsen the psychotic or bipolar symptoms.
- Advise them about maintaining a healthy lifestyle, e.g. a balanced diet, physical activity, regular sleep, good personal hygiene, and no stressors. Stress can worsen psychotic symptoms. *Note: Lifestyle changes should be continued as long as needed, potentially indefinitely. These changes should be planned and developed for sustainability.*

2.2 Reduce stress and strengthen social supports

- Coordinate with available health and social resources to meet the family's physical, social, and mental health needs.
- Identify the person's prior social activities that, if reinitiated, would have the potential to provide direct or indirect psychological and social support, e.g. family gatherings, outings with friends, visiting neighbors, social activities at work sites, sports, and community activities. Encourage the person to resume these social activities and advise family members about this.
- Encourage the person and carers to improve social support systems.

CLINICAL TIP
Ensure persons with psychosis are treated with respect and dignity. For further details go to **» ECP.**

2.3 Promote functioning in daily living activities

- Continue regular social, educational and occupational activities as much as possible. It is best for the person to have a job or to be otherwise meaningfully occupied.
- Facilitate inclusion in economic activities, including culturally appropriate supported employment.
- Offer life skills training and/or social skills training to enhance independent living skills for people with psychosis and bipolar disorders and for their families and/or carers.
- Facilitate, if available and needed, independent living and supported housing that is culturally and contextually appropriate in the community.

2.4 General advice for carers

- Do not try to convince the person that his or her beliefs or experiences are false or not real. Try to be neutral and supportive, even when the person shows unusual behaviour.
- Avoid expressing constant or severe criticism or hostility towards the person with psychosis.
- Give the person freedom of movement. Avoid restraining the person, while also ensuring that their basic security and that of others is met.
- In general it is better for the person to live with family or community members in a supportive environment outside of the hospital setting. Long-term hospitalization should be avoided.

National Council for Behavioral Health

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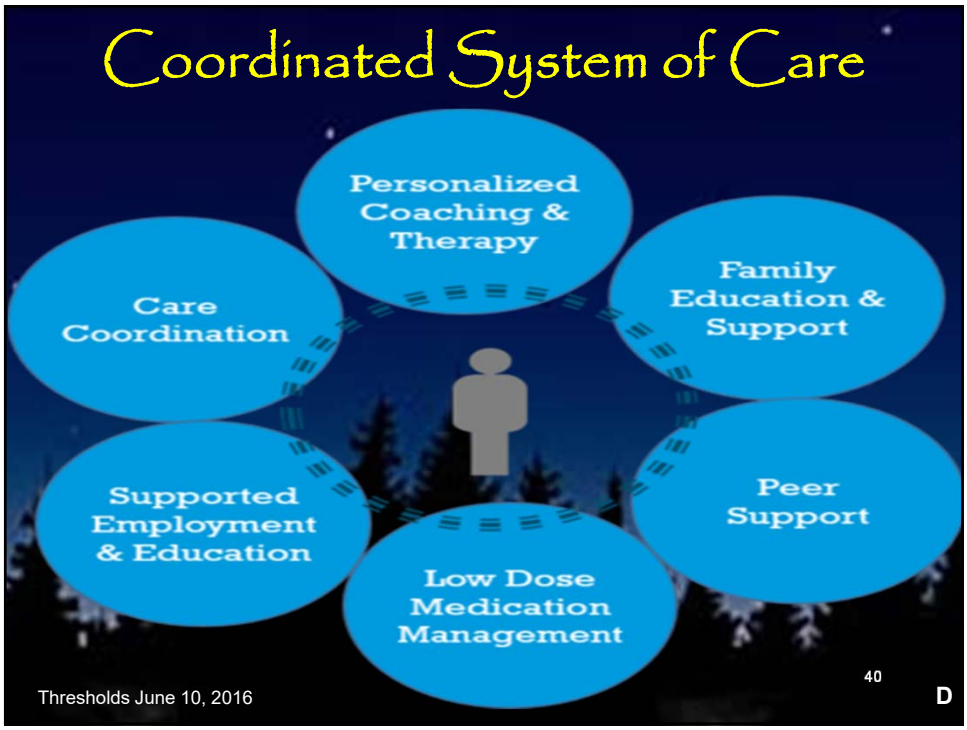
Coordinated System of Care



Thresholds June 10, 2016

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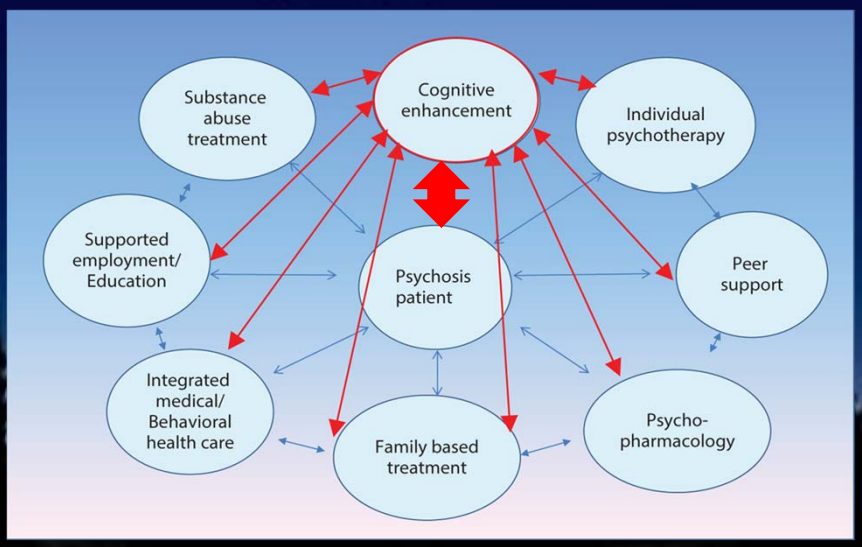
Approaches to Cognitive Enhancement



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Key Messages in Treatment of High Risk Psychosis

1. Life Function – Improved vocational preparation
2. Life Fulfillment – CBT, MET
3. Financial stability – work and financial planning
4. Fun – Recreation, Art therapy
5. Family/peers – Education, support groups
6. Physical Health – Public health and preventive care
7. Focus on the other problems –Anx, Dep, PTSD, SUD
8. Maximize personal choice CBT, MET

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Psychotropic Medications not Seen as choice in Ultra High Risk Psychosis

- Evidence suggests that minimizing antipsychotic load during recovery allows for optimal functional recovery, despite an increasing risk of relapse.

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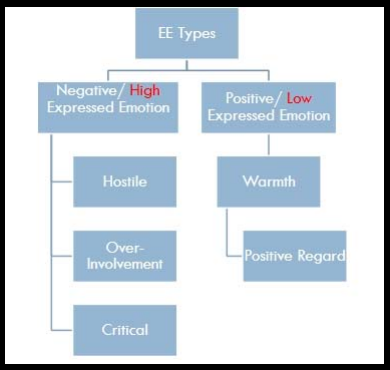
Expressed Emotion (EE) and High-Risk for Psychosis

- **What is EE?**



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Expressed Emotion (EE) and High-Risk for Psychosis

- **Why is EE important?**
  - ✓ **30 years of research has established a strong relationship between EE in the home and the course of schizophrenia.**
  - ✓ **~50% relapse rate in families with high EE and ~ 20% relapse rate in families with low EE (Butzlaff & Hooley, 1998; Kavanagh,1992).**
    - ✓ **EE's negative impact more pronounced with chronic cases**

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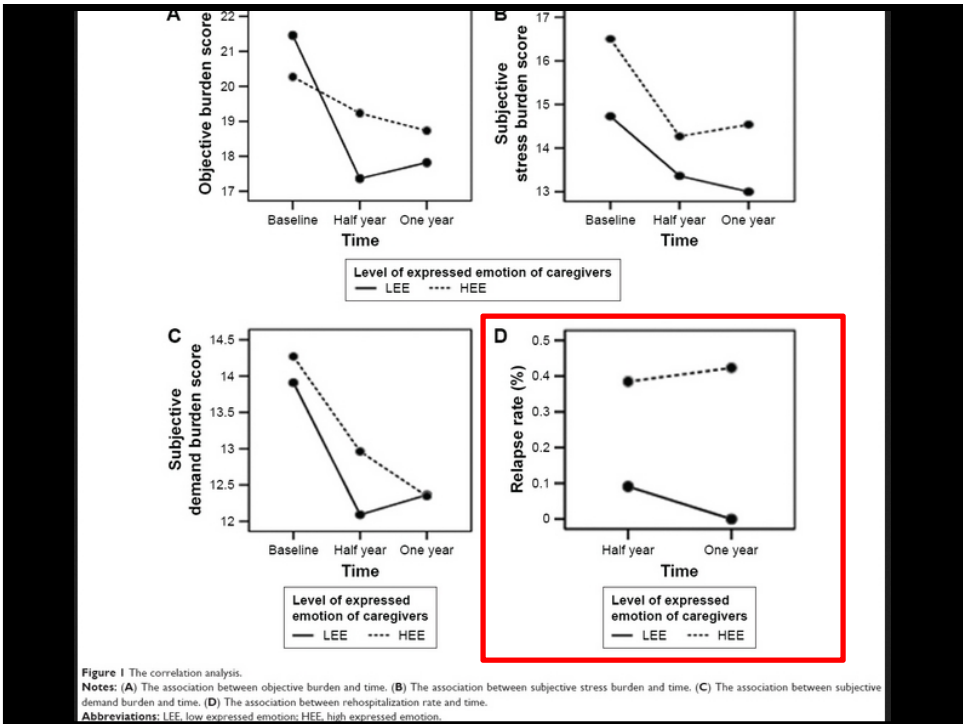

Figure 1 The correlation analysis.
Notes: (**A**) The association between objective burden and time. (**B**) The association between subjective stress burden and time. (**C**) The association between subjective demand burden and time. (**D**) The association between rehospitalization rate and time.
Abbreviations: LEE, low expressed emotion; HEE, high expressed emotion.

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Expressed Emotion (EE) and High-Risk for Psychosis

- **Why is high EE deleterious to a patient's course?**

✓**over-stimulates the patient**

✓**impairs ability to cope**

✓**contributes to social withdrawal**

✓**leads to perception of poor family support**

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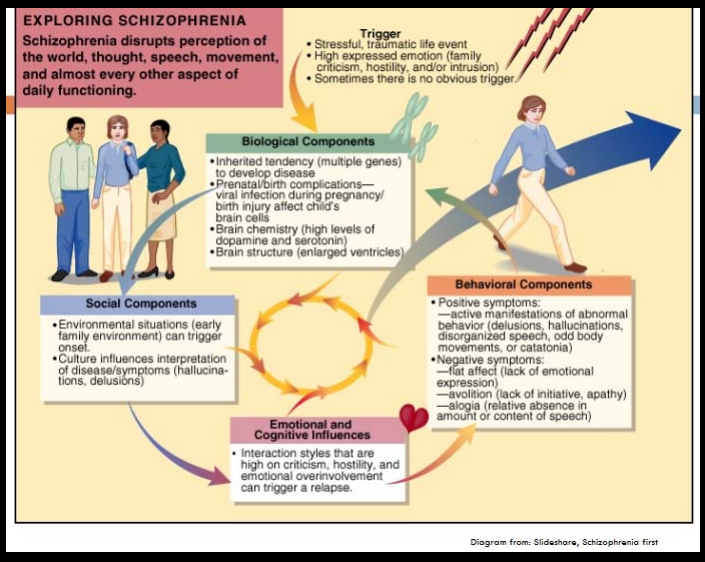

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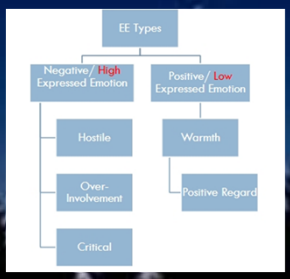
Expressed Emotion (EE) and High-Risk for Psychosis

- Five features of High EE
  1. criticism
  2. hostility
  3. emotional over-involvement
  4. warmth (absence)
  5. positive comments (absence)



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Expressed Emotion (EE) and High-Risk for Psychosis

1. Criticism = comments about the behavior or characteristics of the patient which he or she clearly resents or is annoyed by.

2. Hostility = patient receives generalized criticisms and perceives rejection by family members.

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Expressed Emotion (EE) and High-Risk for Psychosis

3. Emotional over-involvement = over-emotionality, excessive self-sacrifice, over-identification, and extreme overprotective behavior with the patient.

4. Warmth (absence) = lack of kindness, concern, and empathy from the caregiver.

5. Positive comments (absence) = lack of appreciation or support via verbal/nonverbal behavior by the caregiver.

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Expressed Emotion (EE) and the Client's Caregiver

- Addressing caregivers with high EE
  - ✓ decrease criticism, hostility and emotional over-involvement
  - ✓ increase warmth and positive comments
    - ✓ Listen and emphasize rather than argue
    - ✓ Keep statements short
    - ✓ Ask questions one at a time; don't rush response
    - ✓ Stay calm; be patient
    - ✓ Use "I" statements
    - ✓ Avoid name-calling and criticizing
    - ✓ Recognize your own limits

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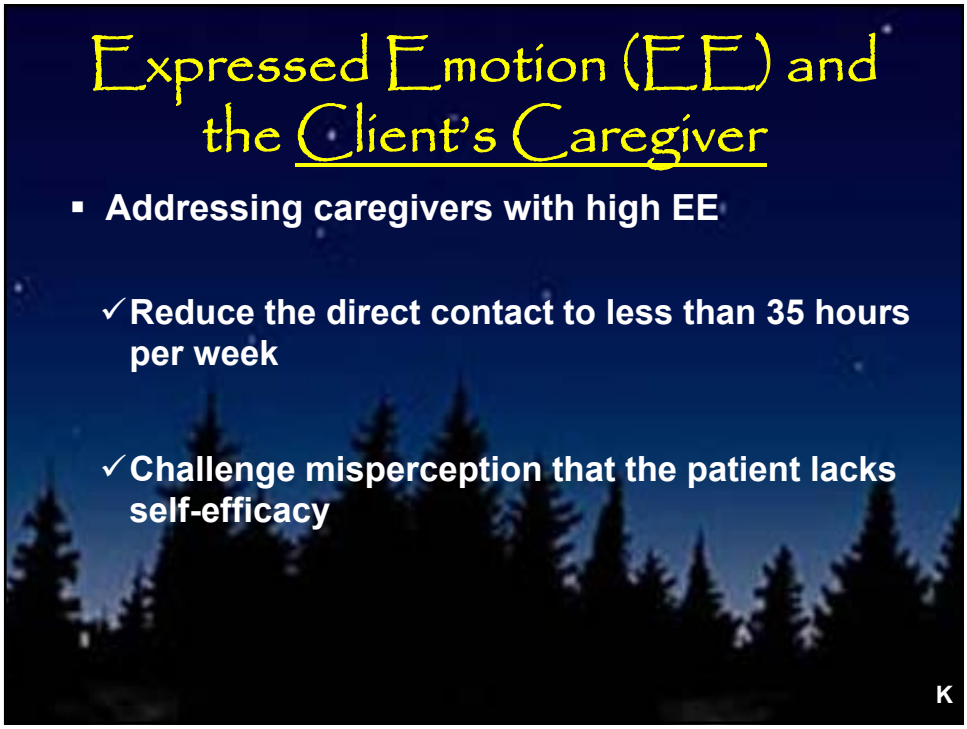
Expressed Emotion (EE) and the Client's Caregiver
Addressing caregivers with high EE
✓Reduce the direct contact to less than 35 hours per week
✓Challenge misperception that the patient lacks self-efficacy
K

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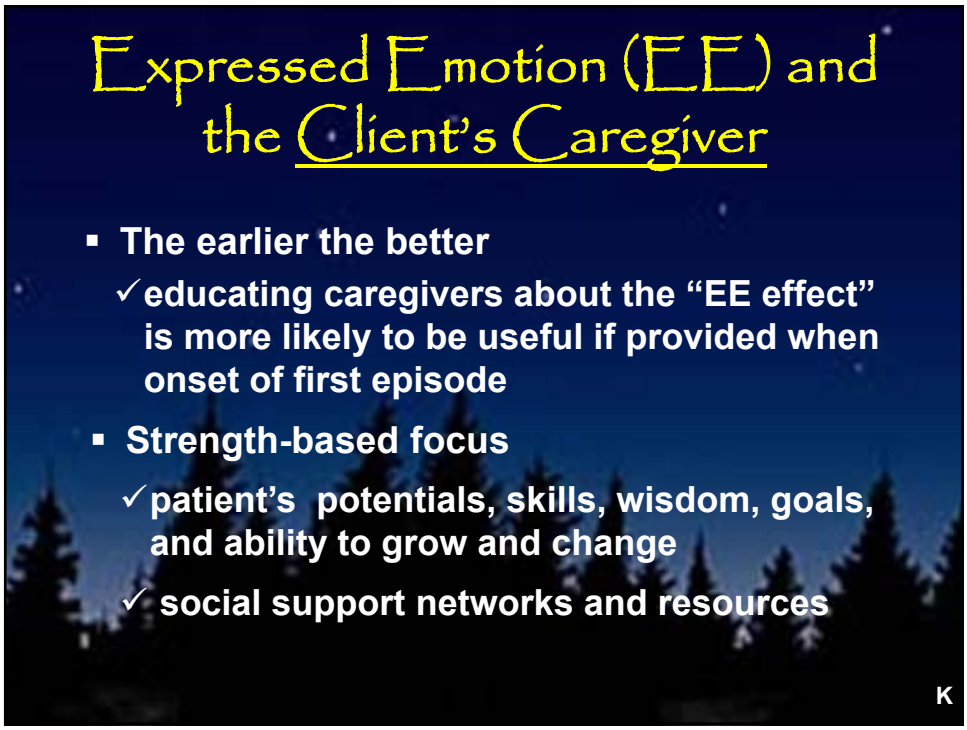
Expressed Emotion (EE) and the Client's Caregiver
The earlier the better
✓educating caregivers about the "EE effect" is more likely to be useful if provided when onset of first episode
Strength-based focus
✓patient's potentials, skills, wisdom, goals, and ability to grow and change
✓ social support networks and resources
K

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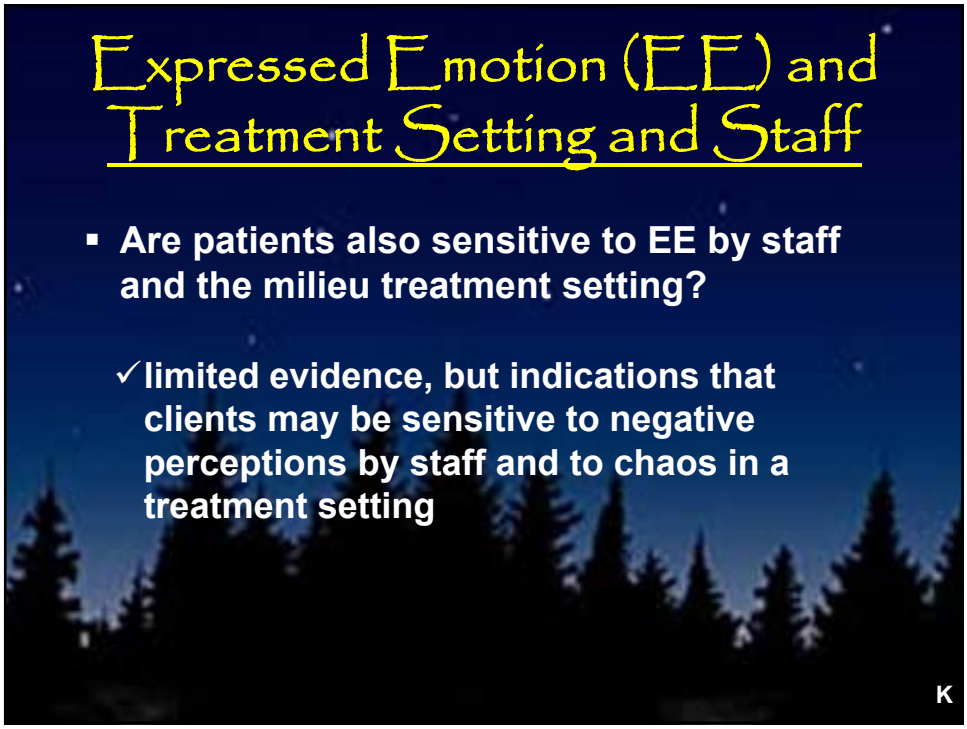
Expressed Emotion (EE) and Treatment Setting and Staff
Are patients also sensitive to EE by staff and the milieu treatment setting?
✓limited evidence, but indications that clients may be sensitive to negative perceptions by staff and to chaos in a treatment setting
K

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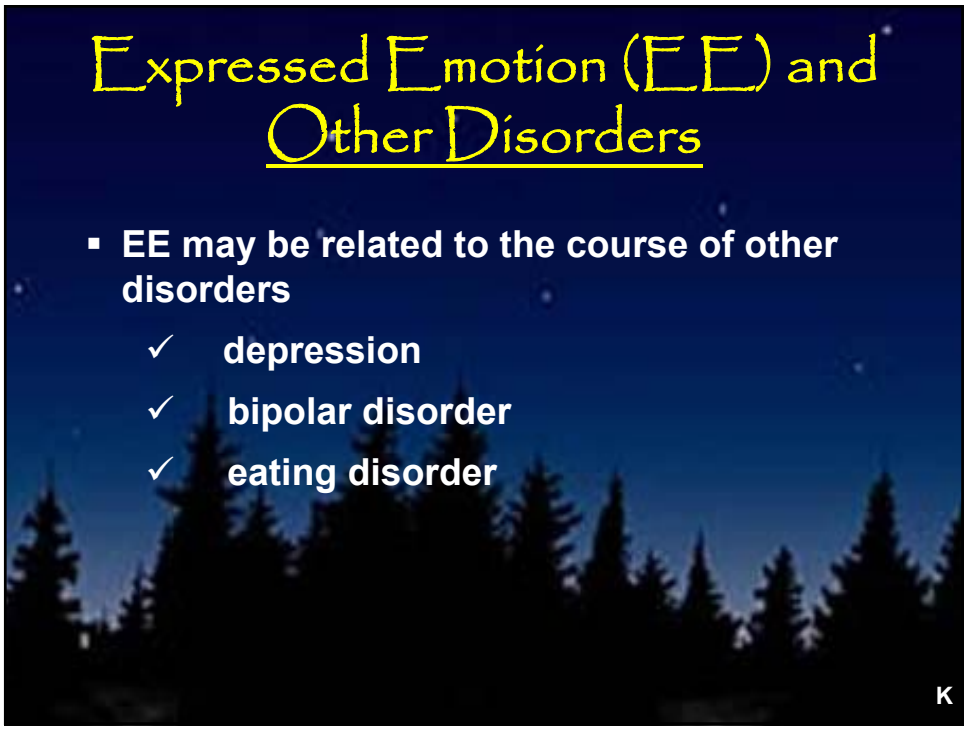
Expressed Emotion (EE) and Other Disorders
EE may be related to the course of other disorders
✓ depression
✓ bipolar disorder
✓ eating disorder
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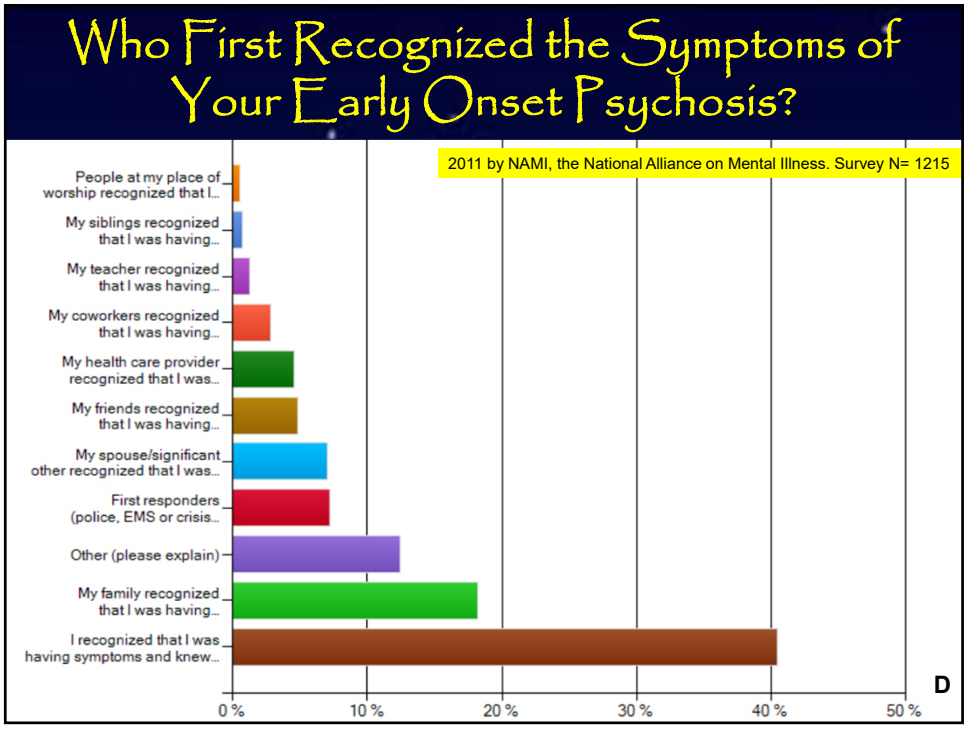
Who First Recognized the Symptoms of Your Early Onset Psychosis?
2011 by NAMI, the National Alliance on Mental Illness. Survey N= 1215
People at my place of worship recognized that I...
My siblings recognized that I was having...
My teacher recognized that I was having...
My coworkers recognized that I was having...
My health care provider recognized that I was...
My friends recognized that I was having...
My spouse/significant other recognized that I was...
First responders (police, EMS or crisis...
Other (please explain)
My family recognized that I was having...
I recognized that I was having symptoms and knew...
0 %
10 %
20 %
30 %
40 %
50 %
D

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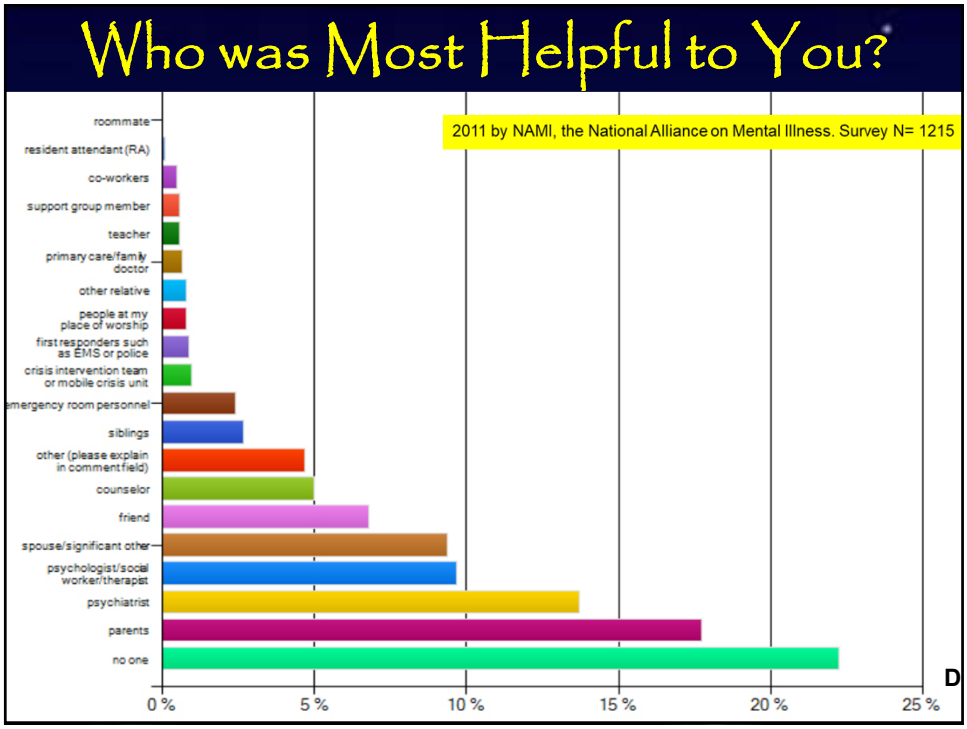
Who was Most Helpful to You?
2011 by NAMI, the National Alliance on Mental Illness. Survey N= 1215
roommate
resident attendant (RA)
co-workers
support group member
teacher
primary care/family doctor
other relative
people at my place of worship
first responders such as EMS or police
crisis intervention team or mobile crisis unit
emergency room personnel
siblings
other (please explain in comment field)
counselor
friend
spouse/significant other
psychologist/social worker/therapist
psychiatrist
parents
no one
0 %
5 %
10 %
15 %
20 %
25 %
D

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Suggestions for People in Psychosis By:

Individuals who had experienced psychosis

2011 by NAMI, the National Alliance on Mental Illness. Survey N= 1215

- Find the right doctor, keep appointments and take your medication
- Find your spiritual strength
- Know what "triggers" your psychosis; avoid them
- Learn stress reduction and management
- Keep a sense of humor
- See a doctor right away when it starts
- Get cognitive behavioral therapy
- Be selective about whom and what you tell, but stay connected to others
- Do what you can incrementally
- Do puzzles and read books
- Yoga
- Don't look back; move forward
- Take care of all the areas of your life: sleep, proper diet, spiritual and social needs, relaxation
- Listen to or read stories of positive role models; people who have had similar experiences
- Learn to trust and cooperate; don't fight

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National American Indian and Alaska Native

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

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