Responding to Risk for Psychosis Among College Students: Tools for Early Engagement, Assessment, and Treatment

COURSE DIRECTORS: MICHELLE L. WEST, PHD; MICHELLE FRIEDMAN-YAKOOBIAN, PHD; KRISTEN WOODBERRY, MSW, PHD; MATCHERI KESHAVAN, MD

SUPPORTED BY: CENTER FOR EARLY DETECTION, ASSESSMENT, AND RESPONSE TO RISK (CEDAR); BETH ISRAEL DEACONESS MEDICAL CENTER (BIDMC) & HARVARD MEDICAL SCHOOL (HMS) CONTINUING EDUCATION PROGRAMS; & COMMONWEALTH RESEARCH CENTER (CRC) OF THE DEPARTMENT OF MENTAL HEALTH (DMH); SIDNEY R. BAER, JR. FOUNDATION

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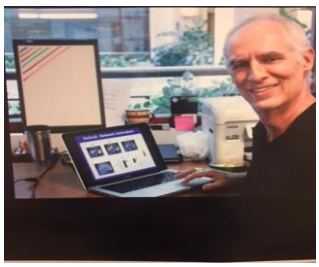
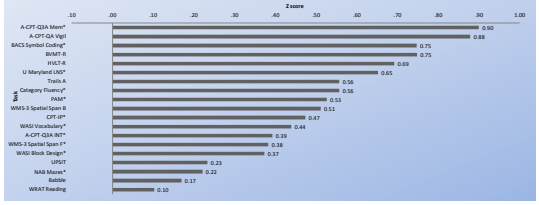
Opening Remarks

William S. Stone, Ph.D.
Department of Psychiatry, Beth Israel Deaconess Medical Center
Massachusetts Mental Health Center
Harvard Medical School
Boston, Massachusetts



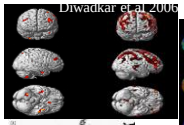
NAPLS-2
Controls vs. CHR Converters



Continuing Gray Matter Loss from premorbid and prodrome phases and continuing after illness onset

Familial high risk offspring

Diwadkar et al 2006



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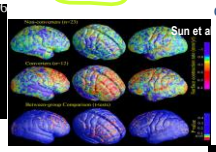
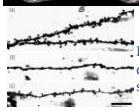
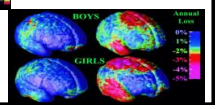


CHR converters

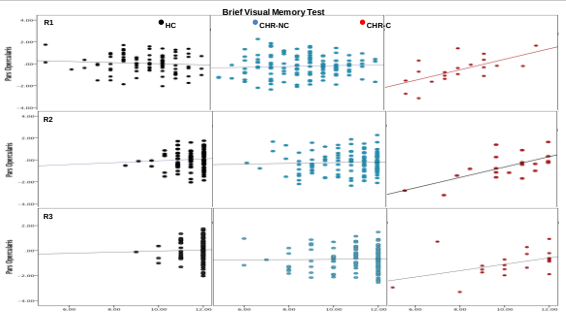
Childhood onset Schizophrenia



Reduced synapse density in schizophrenia



Glantz, L. A. et al. Arch Gen Psychiatry 2000;57:65-73



Early Intervention Turns the Tide: Psychosis and College Mental Health

Vinod H. Srihari, M.D.
P.I. and Director, STEP
www.step.yale.edu

DISCLOSURES

Vinod H. Srihari, M.D.
Director, STEP Program
www.step.yale.edu

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Yale University

Connecticut Mental Health Center

National Institutes of Health

Population Based Early Intervention for Psychosis:
The STEP Program

I. The public health challenge

II. Evidence for Early Intervention Service (EIS) for Psychotic illnesses

III. The Population Health framework

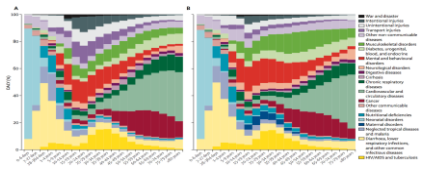
IV. Earl(ier) intervention before the onset of psychosis

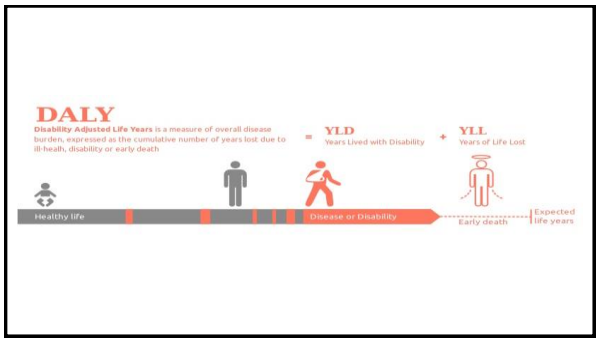
I. Psychotic illnesses

The Public Health challenge

Burden of Neuropsychiatric Illness

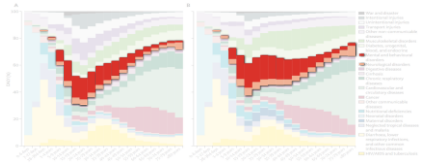
Percentage of global disability-adjusted life years by age, sex, and cause in 2010





Mental illnesses are *"chronic diseases of the young"*

Percentage of global disability-adjusted life years by age, sex, and cause in 2010



Leading causes of Years Lived with Disability (YLD) worldwide
(Source: Global Burden of Disease, 2010 Lancet. 2012;380(9859):2163–2196.

El Loco, Picasso 1909

Clinical Features

Syndromes that can (but do not always) include 5 symptom clusters:

1. 'Positive' symptoms: 'Psychosis'
   - Reality distortion (delusions, hallucinations)
   - Disorganization (thought, behavior, expression of feeling)

Clinical Features

2. 'Negative' symptoms
   - lack of motivation (*avolition*)
   - reduction in spontaneous speech (*alogia*)
   - social withdrawal (*apathy*)

Loss of anticipatory but not consummatory pleasure

(Felix Garcia, d. 1941)

Clinical Features

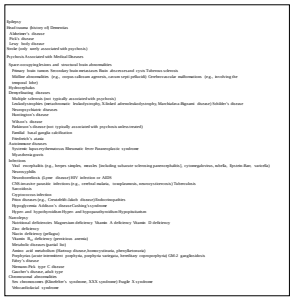
3. Cognitive deficits
   - Memory (working and long term)
   - Attention, processing speed
   - Executive functioning
   - Social cognition

4 & 5. Affective dysregulation
   - Depressive symptoms
   - Manic symptoms

Secondary Psychosis

- Consider life-threatening causes (delirium, including EtOH w/d)
- Consider easily diagnosed and treatable (e.g. syphilis, thyroid)
- Consider common (primary)
- Remain alert for uncommon presentations of illnesses requiring different Rx (e.g. epilepsy)

Sources: Coleman & Gillberg (1996), Coleman & Gillberg (1997),Goff et al. (2004), and Hyde & Lewis (2003).


Delirium
Dementia (history of) Dementias
Down's syndrome
Fitz's disease
Lewy body disease
Stroke (only rarely associated with psychosis)

Psychosis Associated with Medical Diseases

Space-occupying lesions and structural brain abnormalities
Primary brain tumors Secondary brain metastases Basic abcesses and cysts Tuberous sclerosis
Vascular malformations (e.g., venous-collector agenesis, cavum septi pellucidi) Cerebrovascular malformations (e.g., involving the temporal lobe)
Epilepsies
Hydrocephalus
Demyelinating diseases
Multiple sclerosis (not typically associated with psychosis)
Leukodystrophies Adrenoleukodystrophy Krabbe disease Metachromatic leukodystrophy Marchiafava-Bignami disease) Schilder's disease
Neurocutaneous diseases
Huntington's disease
Wilson's disease
Parkinson's disease (not typically associated with psychosis unless treated)
Basal ganglia calcification
Paraneoplastic syndromes
Recruitment diseases
Systemic lupus erythematosus Rheumatic fever Paraneoplastic syndrome
Myasthenia gravis
Infections
Viral encephalitis (e.g., herpes simplex, measles [including subacute sclerosing panencephalitis], cytomegalovirus, rubella, Epstein-Barr, varicella)
Neurosyphilis
Neurobrucellosis (Lyme disease) HIV infection or AIDS
CNS invasive parasitic infections (e.g., cerebral malaria, toxoplasmosis, neurocysticercosis) Tuberculosis
Fungal infections
Toxoplasmosis infections
Prion diseases (e.g., Creutzfeldt-Jakob disease) Endocrinopathies
Hypoglycemia Addison's disease/Cushing's syndrome
Hyper- and hypothyroidism Hyper- and hypoparathyroidism Hypopituitarism
Neurology
Nutritional deficiencies Magnesium deficiency Vitamin A deficiency Vitamin D deficiency
Zinc deficiency
Niacin deficiency (pellagra)
Vitamin B_{12} deficiency (pernicious anemia)
Folate deficiency (partial list)
Metabolic and intoxication illnesses diseases Acute intermittent porphyria (acute intermittent porphyria, porphyria variegata, hereditary coproporphyria) GM-2 gangliosidosis
Tay's disease
Niemann-Pick type C disease
Mucolipidosis type IV disease
Chromosomal abnormalities
Sex chromosomes (Klinefelter's syndrome, XXX syndrome) Fragile X syndrome
Velocardiofacial syndrome

Primary Psychotic Disorders

The current *Field-Guide** approach to classification (DSM 5)

Non-affective psychotic disorders
- Schizophrenia
- Schizoaffective disorder
- Schizophreniform disorder
- Delusional disorder
- Brief psychotic disorder/ Schizophreniform disorder
- ~~Psychotic disorder not otherwise specified~~
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
- Other specified Schizophrenia Spectrum and Other Psychotic Disorder

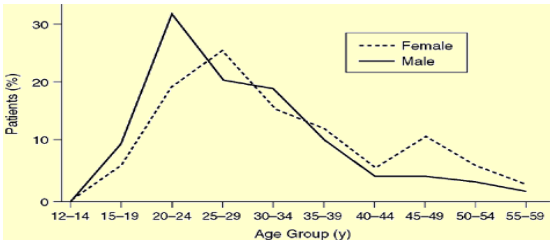
The Schizophrenia(s)

Affective psychoses
- Bipolar disorder with psychotic features
- Major depressive disorder with psychotic features

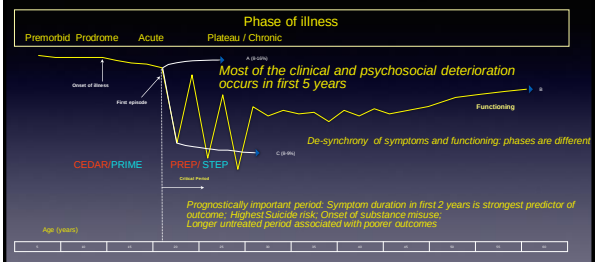
*Paul McHugh, NEJM 2012

Age at onset of schizophrenia (syndrome)

(Hafner, Maurer, Loffler & Reicher-Rossler, 1993)

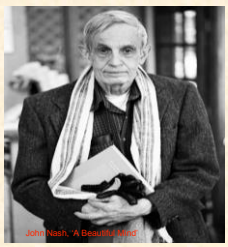


Course of the Schizophrenia(s): Opportunities for Early Intervention



from Srihari et al. Psych Clin of N America, 2012

The Schizophrenia(s) Prognostic Heterogeneity


John Nash, "A Beautiful Mind"


Elyn Saks, "The Center Cannot Hold"


Felix Garcia

I. Summary

- Psychotic illnesses are distressing, disabling and costly
- These are chronic illnesses of the young
- Early intervention addresses a critical opportunity to change illness trajectories
- EI for psychosis will have global relevance for other neuropsychiatric illnesses

II. Early Intervention Services (EIS) for Psychosis

What is the Evidence?

'Early Intervention' Services

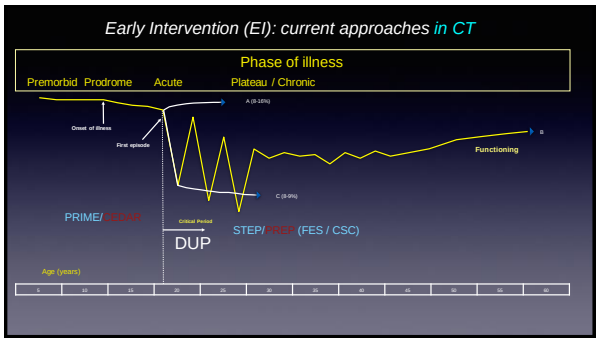
for Psychotic Disorders

A. Early Detection (**ED**)

- Shortening the Duration of Untreated Psychosis (DUP)

B. Intensive Treatment in first 2-5 years (First-Episode Services **FES** or Coordinated Speciality Care, **CSC**)

– Focus on reducing relapse & maximizing functioning
– Interventions adapted from chronic SMI to younger patients
– Goal of 'phase-specific' intervention



The Evidence for EI

A. ED: Intervening earlier (even without enriching care) appears to have durable effects on outcome (Hegelstad et al, 2012)

B. **FES:** Intervening intensively after the onset of psychosis improves outcomes over usual care (OPUS, Lambeth, STEP and RAISE studies) at 2+ years (reviewed in Srihari et al., 2012, Srihari et al., 2015, Kane et al., 2015)

The Clinic for Specialized Treatment Early in Psychosis (STEP) est. 2006

- **Pragmatic RCT (2007-'13)**
  - Broad recruitment
  - Feasible interventions
  - Relevant outcomes

- **Based in public sector**
  CMHC: *DMHAS-Yale partnership*
- **Addressed barriers to access**
  - Insurance status
  - Catchment of residence
  - Adolescent-Adult agencies

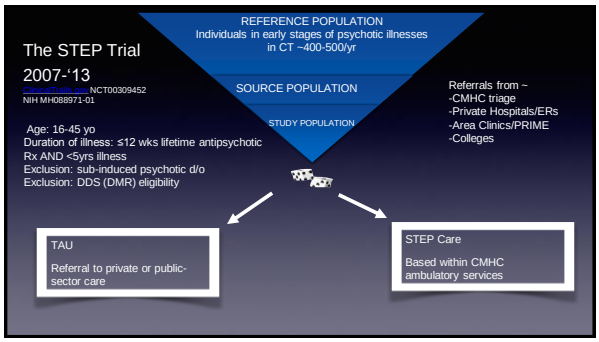
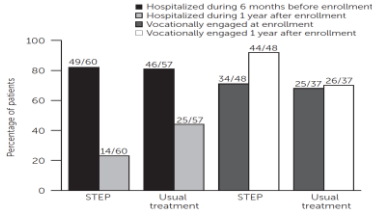


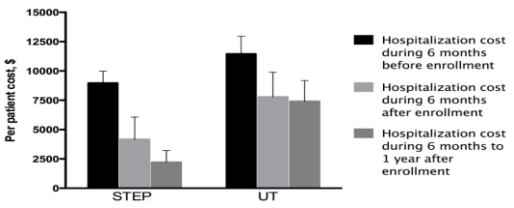
FIGURE 1. One-year hospitalization and vocational engagement outcomes among STEP participants and those in usual treatment[a]



1. NNT of 5 for Hospitalization over first year
2. Fewer in STEP had 'dropped' out of labor force 8% (vs. 33% in Usual Treatment)

Srihari et al., Psych Services 2015

STEP progressively reduced frequency, duration of acute hospitalizations



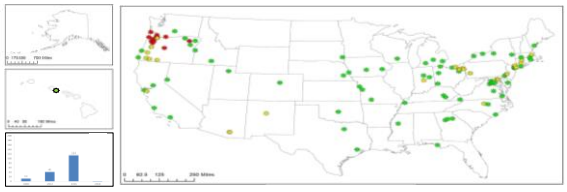
II. Summary

- Early Detection has demonstrated long-term impact in Norway; STEP is leading first US attempt to replicate this. ('Mindmap' campaign)
- FES (implemented as CSC in US) is a 'best bet' per 2 US RCTs (STEP and RAISE)
- Dissemination is the next U.S. frontier

Public FES clinics before 2008

from Robert Heinssen, NIMH

FES after SAMHSA set-aside



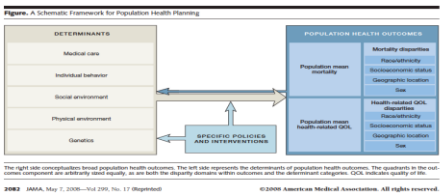
from Robert Heinssen, NIMH

Looking ahead to 2018

from Robert Heinssen, NIMH

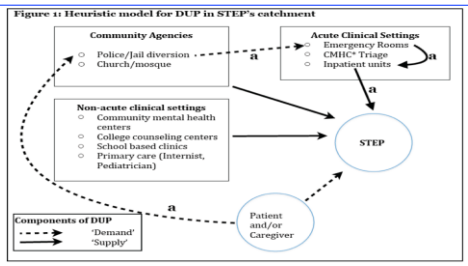
III. Population Health Systems

Population Health framework: thinking critically about medical care and outcomes



(David Kindig)

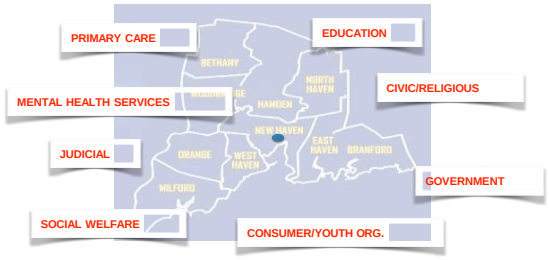
Psychosis in the U.S.: tortuous **pathways to care**



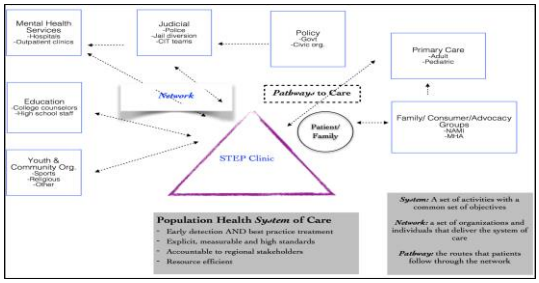
Goldberg-Huxley model of the pathway to psychiatric care: Levels & Filters

Huxley P. Nordic J of Psychiatry 1996;50(S37):47-53.

Distributed **Networks** *of care*



Vision for a Population Health Based *System* of Care



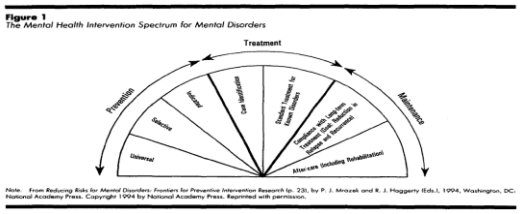
III. Summary

- A Population Health framework can put into proper perspective the role of health care (vis a vis other actors) in achieving the goal (health outcomes)
- Systems - Network - Pathways concepts can help make EI operational for psychotic disorders

IV. Earl(ier) intervention before the onset of psychosis

Turning back the tide

Early Interventions for Neurodevelopment Disorders:
Prevention or Treatment?

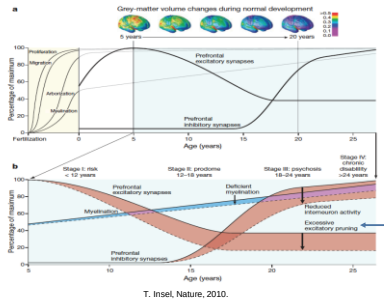


Note. From *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (p. 23), by P. J. Mrazek and R. J. Haggerty (Eds.), 1994, Washington, DC: National Academy Press. Copyright 1994 by National Academy Press. Reprinted with permission.

"…the term prevention be reserved for only those interventions that occur before the initial onset of a clinically diagnosable disorder."

Munoz et al., American Psychologist 1996

The Schizophrenia(s): a neurodevelopment model



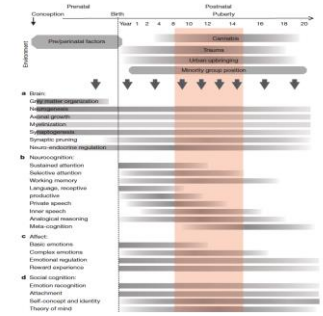
T. Insel, Nature, 2010.

Early and Late 'second-hit' environmental insults

Cortical thinning w/o cell death

Microglial pruning driven by complement system?

Sekar, Nature 2016



Van Os, Nature, 2010

..And other Environmental risk factors

- Winter birth
- Paternal age
- prenatal maternal stress
- prenatal maternal nutritional deficiency
- maternal serum lead and homocysteine levels
- rhesus incompatibility,
- low and high neonatal vitamin D
- prenatal toxoplasmosis
- specific viral and bacterial infections
- miscellaneous pregnancy and birth complications (PBC)
- MJ use

IV. Summary

- Interventions for populations 'at risk' for psychosis are a necessary part of the spectrum of interventions for psychotic disorders
- Work on risk reduction can succeed without firm knowledge on pathophysiology
- ….or predictive certainty (we may be better at preventing than predicting)
- Developmental timing is key: college age youth are an essential target population



Screening, Assessment Tools, and Diagnostic Considerations for Psychosis Spectrum Symptoms

Megan Graham, LMHC
mgraham1@bidmc.harvard.edu
CEDAR Programs
Commonwealth Research Center (CRC)
Beth Israel Deaconess Medical Center (BIDMC)

Janine Rodenhiser-Hill, Ph.D.
jodenhi@bidmc.harvard.edu
CEDAR Programs
Commonwealth Research Center (CRC)
Beth Israel Deaconess Medical Center (BIDMC)

Disclosures

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Observing and Listening For Psychosis Spectrum Experiences

- Psychosis can present with varying signs and symptoms
- Diversity in clinical presentation necessitates adopting a multi-method, culturally sensitive assessment approach

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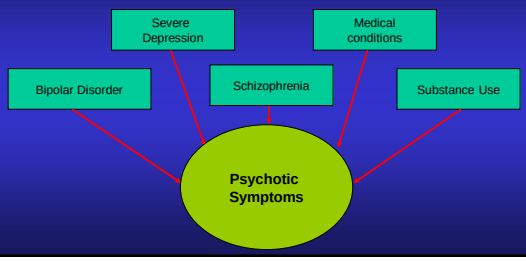
Psychosis

- Set of symptoms, NOT a diagnosis
- "Positive" symptoms:
  - Hallucinations (hearing voices, seeing shadows/visions)
  - Delusions (inflexible false beliefs)
  - Disorganized speech or behavior
- "Negative" symptoms
  - Trouble showing emotion
  - Low motivation
  - Not talking much
  - Declined functioning/withdrawal

Multiple conditions involving psychosis



Indicators Of Risk for Psychosis

Unusual Ideas/ Delusional Beliefs	Unanticipated mental events/ ideas of reference/ mind tricks, magical thinking, external control.
Suspiciousness/ Paranoia	Clear or compelling thoughts of being watched or singled out. Sense that people intend to harm. Loosely organized beliefs about danger or hostile intention.
Grandiosity/ Inflated Sense of Self	Notions of being unusually gifted, powerful, or special. Promotes significantly unrealistic plans.
Perceptual Abnormalities/ Hallucinations	Repeated unformed images, recurrent illusions or momentary hallucinations that are recognized as not real but may be worrisome, captivating, or affect thinking or behavior.
Disorganized Communication	Occasional incorrect words, irrelevant topics. Frequently going off track. Circumstantial. Tangential. Loosening of associations under pressure.

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Clinical Signs of Risk for Psychosis

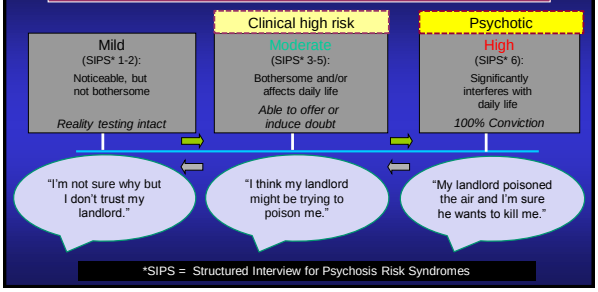
- Drop in grades/ work performance
- Having strange feelings or no feelings at all
- Trouble concentrating
- Decline in self-care
- Social withdrawal
- New sensitivity to sights or sounds
- Hearing whispers, seeing shadows
- Feeling "like your mind is playing tricks on you"
- Suspiciousness
- Unusual/ intense ideas

Especially if:
- Close relative with mental illness/psychosis
- New/worse, recurring, & has negative impact

Structured Interview for Psychosis-Risk Syndromes (SIPS; Miller et al, 2002)

- Semi-structured clinical interview
  - Probe questions, combined with follow-up & clinical judgment
- Positive symptoms (P1-P5)
  - Unusual thought content, suspiciousness/paranoia, grandiosity, perceptual disturbances, & disorganized speech
- Negative symptoms (N1-N6)
  - Social anhedonia, avolition, expression of emotions, experience of emotions/self, ideational richness, occupational functioning
- Disorganized symptoms (D1-D4)
  - Odd behavior/appearance, bizarre thoughts, attention trouble, hygiene
- General symptoms (G1-G4)
  - Sleep disturbance, dysphoric mood, motor disturbance, impaired tolerance to stress

Psychosis Continuum



*SIPS = Structured Interview for Psychosis Risk Syndromes

Psychosis Spectrum Symptoms: Sub-threshold, Attenuated, & Psychotic

Symptom	Minimally Present	Attenuated (CHR) Level	Psychotic Level
Unusual Ideas/ Beliefs	I vaguely feel like something has changed; I'm distracted by daydreaming	I make connections between unrelated events; thoughts may be put into my head	I'm convinced that the TV sends me messages; I know that Satan controls my mind
Suspicious-ness/ Paranoia	I'm feel slightly guarded with my peers; people may dislike me	I have the thought that cameras may be monitoring me; people may have it in for me	I know that my neighbors are conspiring to kill me
Grandiosity/ Inflated Sense of Self	I think I can make the honor roll even though my grades are poor	I'm smarter than my peers & will make great changes in the world, but tend not to tell people	I know that I'm famous; I have the power to control the space-time continuum
Perceptual Abnormal-ities	Noises/lights bother me more than they used to	I see shadows out of the corner of my eyes; I hear whispers; I hear voices but they're in my head	I hear 3 voices - they're real people and bad things will happen if I don't do what they say
Disorganized Communic-ation	Speaks clearly, sometimes uses a word or phrase that doesn't fit	Goes off track when speaking, jumps to different topics, can respond to structure	Has unintelligible speech that is not responsive to outside attempts to structure

16-Item Prodromal Questionnaire (PQ-16)

- 16 true/false items
- If young person endorses item, they're asked to rate their level of distress, from none to severe
- Items include:
  - I feel uninterested in things I used to enjoy.
  - I often seem to live through events exactly as they happened before.
  - My thoughts are sometimes so strong that I can almost hear them.
  - I sometimes see special meanings in advertisements, shop windows, or in the way things are arranged around me.
  - I often feel that others have it in for me.

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How to ASK about Signs of Risk

- Are you ever confused if something you've experienced is real or imaginary?
- Do you ever feel that your mind is playing tricks on you?
- Have you ever felt that you are not in control of your own ideas or thoughts?
- Do you find that you're more sensitive to sounds? Or hear things other people don't hear?
- Are you more sensitive to light? Do you ever see flashes, flames, vague figures, or shadows out of the corner of your eyes?
- Are you having more trouble understanding what people are saying? Getting your point across?

Follow-Up Questions

- Have you ever felt that you are not in control of your own ideas or thoughts?
  - Tell me more about that.
  - What do you make of it?
  - How often are you having that thought?
  - When did it start?
  - Do you ever do anything differently as a result of that thought?
  - How certain are you about that thought, from 0 to 100?
  - Is there any other explanation? Any chance this is not really happening?

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Tricky Differentials

Is it early psychosis or…

- Autism spectrum?
- ADHD exacerbated by increased demands?
- Social Anxiety?
- OCD?
- Drugs?
- Non-pathological beliefs/experiences common in a person's culture?
- Trauma?
- OR BOTH?

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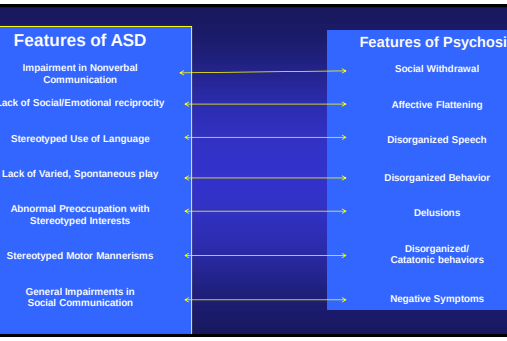
64

"Autism-Plus" Spectrum Disorders

- The core social communication deficits and restricted, repetitive behaviors and interests in patients with ASDs can be misinterpreted as possible hallmarks of a psychotic disorder because of the abnormal thought patterns associated with ASDs

65



There is a subset of individuals with ASD who present with a pattern of transient hallucinations, excessive mood lability and anxiety, social deficits, and excessive interest in fantasy.

These youth are at risk for developing more significant psychiatric comorbidity in adolescence and young adulthood.

67

Individuals with COS frequently have a history of premorbid ASD

There is evidence of a connection between ASD and SSD that warrants a careful assessment for comorbidity

68

ADHD
Attention Deficit Hyperactivity Disorder

69

ADHD

- Prevalence up to 1 in 20 youth (US)
- Fundamental to a diagnosis are impairments in executive functioning and in domains of inattention, impaired behavioral inhibition, and (sometimes) increased motor activity
- Evidenced by Age 12, in 2 or more settings, Cause impairment

70

ADHD

- Often co-morbid with affective disorders, anxiety, substance use disorders, and other behavioral, and developmental disorders
- Multiple studies of long term outcomes in youth with ADHD do not show a significant progression to a diagnosis psychotic illnesses
- True ADHD likely does not exist either as a precursor to or as a comorbid disease

71

Psuedo- ADHD

Characterizes people presenting with attentional difficulties in the prodrome of a psychotic spectrum illness who are incorrectly diagnosed with, or treated for "new onset" ADHD, prior to the presentation of frank psychotic symptoms

72

Common Scenario

- High school or college student presents with complaints of "inability to focus" and difficulty completing academic work
- A diagnosis of ADHD is made, and stimulants (the first line treatment for ADHD) are prescribed
- Days to months later, full psychosis ensues

73

What Can We Do?

- Disturbances in attention should be examined in their full contexts
- Thorough Evaluation of symptomatic Onset, along with other symptom domains- Cognitive (attention, memory, executive functioning, processing speed), Social, Emotional, Psychological, Perceptual- is necessary
- Family and Neurodevelopmental history also should be taken

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Social Anxiety is common in psychosis

(Morbid estimates 25% and thought to be correlated to paranoia)

Social anxiety can be an **effect** of early psychosis (internalized stigma)

Anxiety in General related to Psychosis

75

Indicators Of Anxiety

Social Anxiety	• Worrying about embarrassing or humiliating yourself • Concern that you'll offend someone, be judged • Intense fear of interacting or talking with strangers • Fear that others will notice that you look anxious • Avoiding doing things or speaking to people out of fear of embarrassment • Avoiding situations where you might be the center of attention • Having anxiety in anticipation of a feared activity or event • Spending time after a social situation analyzing your performance and identifying flaws in your interactions • Expecting the worst possible consequences from a negative experience during a social situation
Generalized Anxiety (GAD)	• Excessive worry and anxiety about health, family, money, work (occurs every day/all day long) • Persistent worry/obsession out of proportion to the actual impact of the event • Inability to set aside or let go of a worry • Inability to relax, restlessness, and feeling keyed up or on edge • Difficulty concentrating, making decisions, handling uncertainty • Carrying every option in a situation all the way out to its possible negative conclusion
Physical Symptoms of Anxiety	• Fast heartbeat. • Upset stomach or nausea • Trouble catching your breath • Dizziness or lightheadedness • Confusion or feeling "out of body" • Diarrhea • Muscle tension

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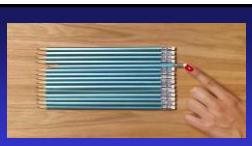

Obsessional Thoughts are Common in Psychosis

We need to Differentiate between Prodrome and OCD

Indicators Of Risk for OCD

Contamination	There are practically no limits to the things that can be contaminating. Examples of contamination fears include bodily fluids, sticky substances, soap, animals, thoughts, colors, names and more. Often result in compulsions.
Symmetry	Intense reactions to anything being asymmetrical, such as words on a page, shoelaces, or any number of things that do not line up evenly
Exactness	Need for everything to be balances. For example, needing to hold a coffee cup with two hands with the same amount of pressure
Forbidden Thoughts	Predispostition to focus on painful or strange thoughts. Often are either aggressive, sexual, religious or somatic
(Hoarding)	DSM5- now its own classification

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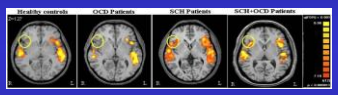

It is estimated that OCD comorbidity for patients with schizophrenia is 23%

Buckley et al
Schizophrenia Bulletin 2009

Obsessions are very common in the prodrome

50 % of OCD cases start by age 19. Patients need early intervention treatment addressing both OCD and psychotic disorders.

When Obsessions May Indicate Co-Morbidity or a Risk for Emerging Psychotic Disorder

80

Substance Use

Known that substances can produce psychosis

There has been an increasing number of studies examining the relationship between cannabis and psychosis, and it is well known that using cannabis can induce temporary psychotic/hallucinatory symptoms.

There is an association between some youth who use cannabis regularly and enduring psychosis.

81

Substance Use

Several recent studies suggest that frequent cannabis use during adolescence is associated with a clinically significant increased risk of developing schizophrenia and other mental illnesses which feature psychosis

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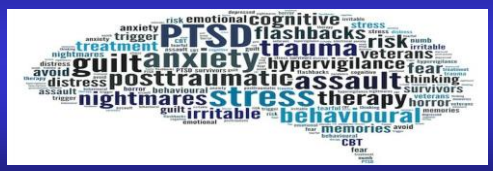
Trauma



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Trauma

Evidence suggests that traumatic events in childhood are significantly related to the development of a psychotic disorder

Similarities between the symptoms of PTSD, dissociation and psychosis have been observed

84

Childhood maltreatment and bullying have been found to be associated with predisposition to hallucinations and delusions

Links between PTSD and psychosis have been found

85

PTSD and Psychosis

- Flashbacks can take the form of auditory, olfactory, tactile and visual hallucinations
- They are often accompanied by paranoia
- Complex reactions to trauma do not easily fit into a straightforward PTSD framework
- Trauma-induced dissociative attachment may render an individual at risk for psychosis

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Vulnerability/Risk

What this *doesn't* mean:
A diagnosis
A prognosis

What this *does* mean:
A warning
An opportunity

BREAK!

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Addressing Risk for Violence and Suicide

MICHELLE L. WEST, PHD
CEDAR CLINIC & RESEARCH PROGRAM
COMMONWEALTH RESEARCH CENTER OF BETH ISRAEL DEACONESS MEDICAL CENTER
MASSACHUSETTS MENTAL HEALTH CENTER

Disclosures

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Overview

- Brief summary of risk assessment
- How may psychotic symptoms impact risk for harm?
- Summary of main ideas

Suicide & Violence Risk Assessment

(Some) Theories of Suicidality

- Interpersonal Theory of Suicide (Joiner, 2005)
  - Thwarted connectedness – feeling you don't belong
  - Thwarted effectiveness – feeling like a burden
- Dialectical Behavioral Therapy (DBT; Linehan, 1993)
  - Desire to stop an overwhelming unpleasant emotional state, emphasizing immediate gratification
- Cognitive Model of Suicidality (Wenzel & Beck, 2008)
  - Dispositional vulnerability factors (e.g., impulsivity, problem solving deficits)
  - Cognitive processes: Underlying negative schemas, hopelessness (things will not get better no matter what)
  - Cognitive Triad: pervasive sense of hopelessness pertaining to self, others, & the future

Suicide Risk Factors

- **SAD PERSONS** (Paterson et al., 1983)
  - **S: S**ex (male)
  - **A: A**ge less than 19 or greater than 45 years
  - **D: D**epression
  - **P: P**revious suicide attempt or psychiatric care
  - **E: E**xcessive alcohol or drug use
  - **R: R**ational thinking loss
  - **S: S**eparated, divorced, or widowed
  - **O: O**rganized plan or serious attempt
  - **N: N**o social support
  - **S: S**tated future intent
- **Additional Suicide Risk Factors**
  - Family history of suicide
  - Access to firearms/lethal means
  - Serious or chronic medical condition
  - Prolonged stress
  - Agitation
  - Sleep deprivation
  - Recent loss or tragedy

Suicide Warning Signs

- **IS PATH WARM** (American Association of Suicidality)
  - **I**deation
  - **S**ubstance Use
  - **P**urposelessness
  - **A**nxiety
  - **T**rapped
  - **H**opelessness
  - **W**ithdrawal
  - **A**nger
  - **R**ecklessness
  - **M**ood Change

Violence Risk Assessment: Overview

- Relationship between violence & serious mental illness is complex
- Substance use: increases risk of violence (for those with & without SMI)
- **Key dimensions:** general criminal recidivism risk factors
  - Antisocial personality traits, psychopathic traits
  - Prior history of violence
  - Housing problems, problems sustaining education/work
  - Criminogenic attitudes (e.g., violence is justified if you need to accomplish something)
  - Criminal associates, limited/criminal support networks
  - Problematic substance use
  - Chronicity/intensity of violent thoughts

Violence Risk Assessment Models

- Unstructured Clinical Judgment & Actuarial Assessment
  - Weaknesses in both!
- **Structured Professional Judgment (SPJ)**
  - Anchored to key static, dynamic, contextual factors
  - Based on empirically known risk variables
    - Improved inter-rater reliability
  - Improved accuracy over unstructured clinical judgment
    - Limits risk of confirmatory & other biases
  - Allows flexibility to take into account low base-rate factors
  - Allows identification of relevant targets of intervention
  - Allows "clinical" focus to decrease risk by focus on dynamic, contextual, & clinical factors that may be most important in each situation

Asking about Suicide & Violence Risk

- Style
  - Be direct, don't avoid the topic
  - Calm demeanor
- Start general (i.e., very common experiences), get more specific
  - For all – check current/recent & lifetime
  - Content of ideation (passive/vague, specific strategies, planning)
  - Urges to act (intensity, response to them)
  - Actions (preparation behaviors, harm behaviors)
  - Details, context related to any endorsed experiences

Sample Questions

- Have you ever wished to stop living or to be dead? / Have you ever wished harm to others?
- Have you had thoughts about hurting yourself? / Have you had thoughts about hurting other people?
- How close have you gotten to acting on these thoughts? Have you ever taken steps to prepare to act?
- Have you ever attempted kill yourself? / Have you tried to injure or injured anyone?
  - When was the last time? What did you do? What was the outcome?
  - How many times in your life?
- What keeps you from acting on your thoughts?
- Do you have access to a gun? Do you keep things that you think about using to harm yourself/others?

Consider Assessment Measures

- May be helpful for clients who exhibit risk for harm that warrants more in-depth assessment
- Suicide risk assessment measures, including:
  - Columbia Suicide Severity Rating Scale (C-SSRS)
  - Collaborative Assessment and Management of Risk (CAMS)
  - Linehan Risk Assessment & Management Protocol (L-RAMP)
- Violence risk assessment measures, including:
  - HCR-20 (Historical – Clinical – Risk Management, 20 items)

How May Psychotic Symptoms Impact Risk for Harm?

General Comments

- Under-reaction & over-reaction – both unhelpful
  - Consequences of under-reaction? Consequences of over-reaction?
  - Easier said than done … finding a balance is difficult!
- Risk tolerance varies across clinicians, contexts
  - Be mindful of your reactions, know & communicate your limits
  - Seek consultation/supervision
- Psychotic symptoms themselves are not necessarily a crisis
  - Clients with both psychosis & risk for harm tend to particularly elicit anxiety
  - Important to assess both
- Consider both risk assessment & risk management
  - Engaging clients in treatment at this stage is key – important protective factor

Three Ways Psychosis May Relate to Risk of Harm

- As a risk factor
- Content of psychosis spectrum symptoms themselves
- As a reaction to experiencing psychosis

As a Risk Factor

- Early psychosis is associated with increased risk of harm to self & others
  - Some first episode psychosis (FEP) research on this association
  - Highly publicized cases that link psychosis & violence (e.g., CO theater shooting) – trigger fear
  - Somewhat less research for CHR stage – still generally supports this idea
- FEP & risk for suicide
  - About 18% with FEP attempted suicide prior to treatment (Challis et al., 2013)
- FEP & aggression towards others (Spidel et al., 2010)
  - 42.7% had a history of physical aggression, 61.5% had a history of verbal aggression
  - Factors associated with increased risk: childhood abuse, psychopathic traits, drug abuse
- Managing risk for harm – case for early intervention (Large, Dall, & Nielssen, 2014)
  - Some indication that risk is higher for untreated psychosis
  - PREP case example

As a Risk Factor – CHR Specifically

- Harm to self & CHR
  - Suicidal ideation is common
    - 82.5% females, 54.6% males endorsed SI (Lindgren et al., 2017)
    - 42.9% endorsed current SI; intensity related to negative symptoms & current functioning (Gill et al., 2015)
  - Increased risk for suicide attempts
    - Large prospective study(age 13-16): within a year, 34% with psychotic symptoms + other psychopathology attempted suicide (Kelleher et al., 2013)
- Harm to others & CHR
  - CHR & violent ideation
    - 21% of CHR population reported some violent images/thoughts (Hutton et al., 2012)

As Content of Psychosis Symptoms

- Clients may describe psychotic symptoms that include violent content
  - Examples: command hallucinations, violent images, violent thought insertion experiences
- Violent content fairly common –CHR sample (Marshall et al., 2016)
  - 48% had some kind of violent content in psychosis spectrum symptoms
  - 71% had self-directed violent experiences, 28% other-directed violent experiences
- Assessment considerations
  - Models for non-psychotic harm-related ideation are helpful guides
  - Include: person's reactions to these symptoms, coping strategies, previous behaviors, available supports, access to relevant means

As a Reaction to Experiencing Psychosis

- Suicidality may be an aspect of a client's reaction to experiencing psychosis spectrum symptoms
  - Meaning of psychotic symptoms for the person (e.g., expectations of worsening symptoms, interference with future goals)
  - Social impact (e.g., stigma, social disconnection/withdrawal, feeling like a burden)
  - Feelings (e.g., hopelessness, numbness, loneliness)
- Aggression towards others may also be an aspect of a client's reaction to psychosis symptoms
  - Meaning of psychosis symptoms (e.g., I am in danger, self-protection)
  - Social impact (e.g., behaving in ways that confuse others, victimization, may lead to aggression)
  - Feelings (e.g., anger)

Risk Management

- Engage client – therapeutic alliance
- Assess risk - risk factors present/absent, protective factors
- Be aware of current resources to support the client
- Identify personal supports
- Identify & reduce access to means for harm
- Reinforce coping strategies
- Highlight hope for improvement

Emphasize Engagement & Help-Seeking

- Factors increasing engagement
  - Collaborative relationship
  - Shared goal development and treatment planning
  - Client-centered goal setting
  - Encouraging the development of a "normal" life/identity as opposed to one rooted in "illness"
  - Time/availability of treatment providers
- Clinician variables that contribute to therapeutic alliance
  - Warm, empathic, rewarding
  - Directive, but non confrontational
  - Flexible
  - Respectful, mutual understanding

Treatment for Risk of Harm

- Assess & target factors that contribute to risk of harm
  - Tailor to client
  - Prioritize targets collaboratively with client, based on assessment of which factors are key
  - Ex: problem-solving, distress tolerance, cognitive restructuring, increase social connection
- Consider & enhance protective factors
  - Support by current, effective mental health treatment
  - Access to a variety of clinical interventions & support to encourage help-seeking
  - Restricted access to highly lethal means for suicide/violence
  - Strong connections to family, friends, community
  - Skills in problem solving, conflict resolution, and nonviolent handling of disputes
  - Skills in managing & distress
  - Cultural/religious beliefs that discourage suicide/violence

Case Example: "Marco"

- Case summary
  - 19 year-old Latino male college freshman
  - Depressive symptoms: numbness, loss of interest/pleasure, negative self-worth
  - Risk of harm to self:
    - Suicidal ideation, fantasies, & planning (chronic), 1 remote suicide attempt (cutting)
    - Some self-harm (cutting/burning)
  - Risk of harm to others:
    - Sees violent visual images of himself harming others, some urges, daily
    - Actions?

Case Example: "Marco"

- Treatment
  - Thorough assessment + remove access to deadly means (guns)
  - Functional analysis of relevant events
  - Reasons for not acting (e.g., fear of being unsuccessful, impact on loved ones)
  - Distress tolerance skills practice
  - Cognitive therapy (e.g., "I am dangerous," "I will injure someone," "I am out of control")

Take Home Points

- **Under-reaction & over-reaction – both unhelpful**
- **Engaging clients in treatment at this stage is key**
- **Psychotic symptoms themselves are not necessarily a crisis**
- **Essential to assess for suicide & violence risk factors in this population**
- **Target risk in treatment/Risk management**

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Innovative Models & Tools for Engaging Youth at Risk

CANDICE PORTER, LICSW
MARSHA ELLISON, PHD
DORI HUTCHINSON, PHD
KRISTEN WOODBERRY, PHD

Psychosis Aware

Candice Porter, LICSW
VP of Outreach & Partnerships
Screening for Mental Health

SMH Screening for Mental Health®

Screening for Mental Health, Inc.

- MISSION: Providing innovative mental health and substance use education and screenings, linking those in need to quality treatment options.
- VISION: Envisioning a world where mental health is viewed and treated with the same gravity as physical health.

COMMUNITY ORGANIZATIONS
WORKPLACES
MINDKARE® KIOSKS
COLLEGES & UNIVERSITIES
MIDDLE & HIGH SCHOOLS
SPECIAL INITIATIVES

What we screen for: depression, bipolar disorder, posttraumatic stress disorder, generalized anxiety disorder, eating disorders, alcohol use disorders, substance use disorders, and adolescent depression

More than 650,000 screenings in 2015 alone

Psychosis Aware

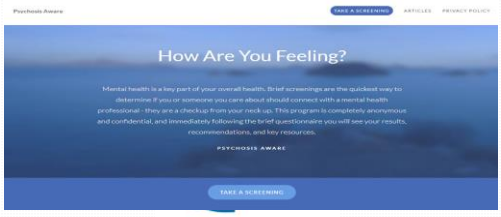
Aims:

- Facilitate early intervention with psychosis screening
- Development of website that will include information about psychosis, online screening, and additional resources based upon our Stop a Suicide Today website (www.stopasuicide.org)
- Online screening will refer to SAMHSA's National Helpline (also known as the Treatment Referral Routing Service)
- Screening for individuals and loved ones

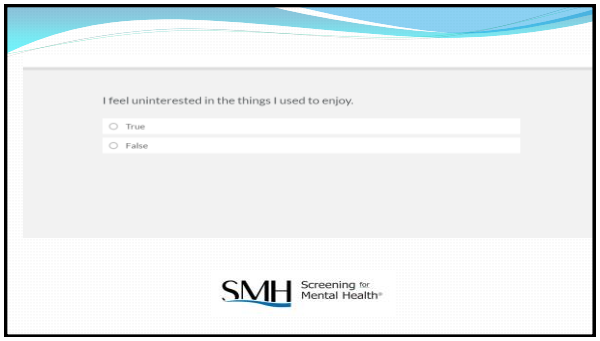
Psychosis Aware

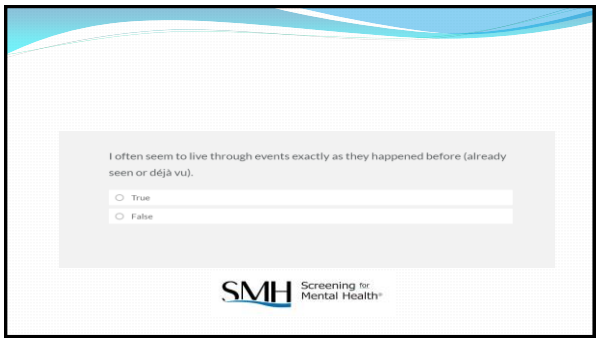
- Working with advisory committee to adapt the PQ-16 and make it available on our online screening program (www.helpyourselfhelpothers.org)
- Develop a basic website (www.PsychosisAware.org) that will link to the screening and have general informational resources for individuals, loved ones, and professionals
- Work on building collaborative relationships to scale both the website and the program up on state and national level
- Expand advisory committee to include colleges and universities to develop targeted programing for these settings – particularly for first episode psychosis

Psychosis Aware



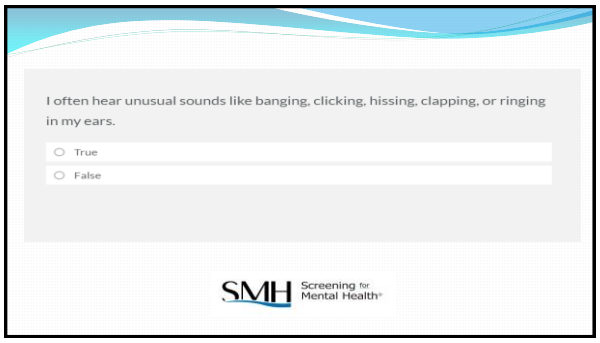

How have you been feeling lately?
Feeling sad, down, or empty
Depression: Community Screening
Depression: Clinical Screening
Constantly worried, anxious
Generalized Anxiety Disorder
Concerned about my teen's mood
Brief Screen for Adolescent Depression
Experiencing mood swings from very high to very low
Bipolar Disorder
Concerned about unusual experiences or behaviors
Psychosis: For Individuals
Psychosis: For Loved Ones
Worried about my drinking habits
Alcohol Use Disorder
Troubled by traumatic events
Posttraumatic Stress Disorder
Afraid of gaining weight or concerned about my eating habits
Eating Disorder
Difficulty controlling my substance use
Substance Use


I feel uninterested in the things I used to enjoy.
True
False
SMH
Screening for Mental Health

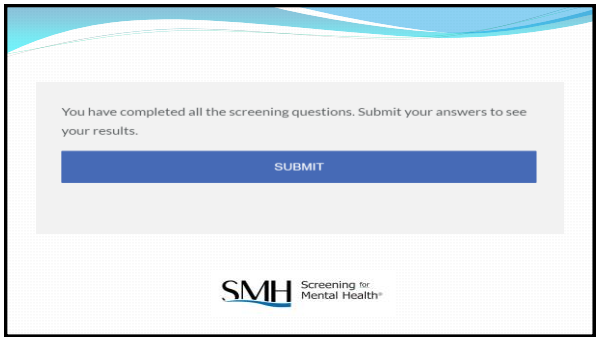

I often seem to live through events exactly as they happened before (already seen or déjà vu).
True
False
SMH
Screening for Mental Health

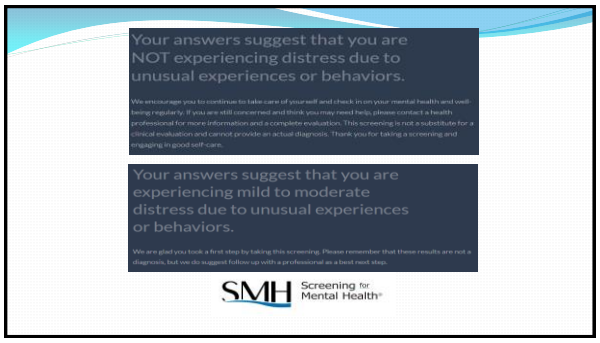

I sometimes smell or taste things that other people can't smell or taste.
True
False
SMH Screening for Mental Health

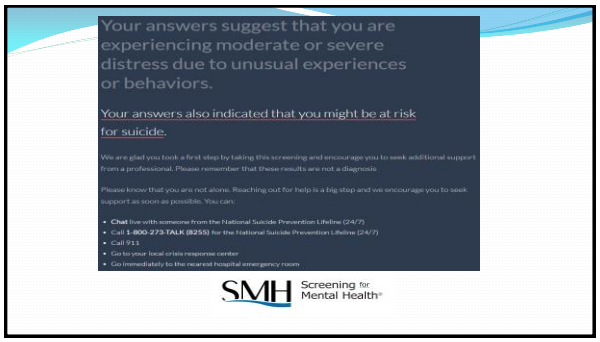

How much discomfort has this experience caused:
None
Mild
Moderate
Severe
SMH Screening for Mental Health

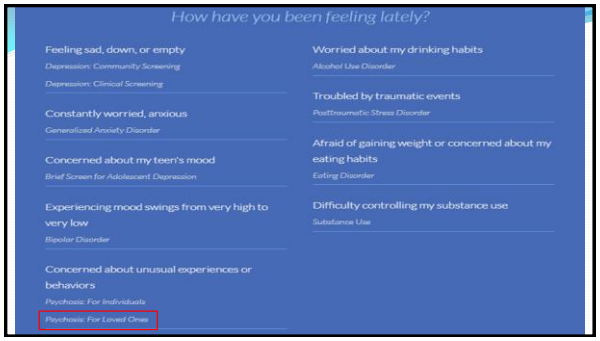

I often hear unusual sounds like banging, clicking, hissing, clapping, or ringing in my ears.
True
False
SMH Screening for Mental Health

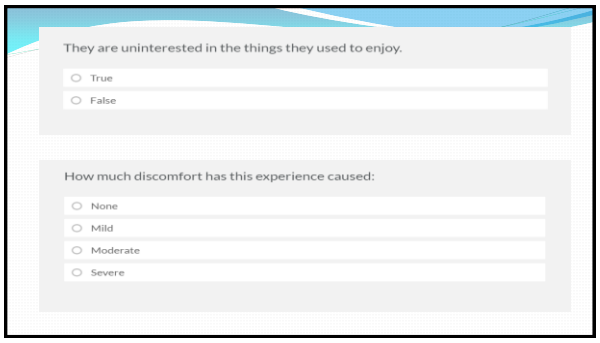

Over the past two weeks, I have had thoughts of wanting to kill myself.
None or little of the time
Some of the time
Most of the time
All of the time
Please explain your mental health treatment history for psychosis.
I am currently being treated
I have received treatment in the past
I have never been treated
SMH Screening for Mental Health


You have completed all the screening questions. Submit your answers to see your results.
SUBMIT
SMH Screening for Mental Health


Your answers suggest that you are NOT experiencing distress due to unusual experiences or behaviors.
We encourage you to continue to take care of yourself and check in on your mental health and well-being regularly. If you are still concerned and think you may need help, please contact a health professional for more information and a complete evaluation. This screening is not a substitute for a clinical evaluation and cannot provide an actual diagnosis. Thank you for taking a screening and engaging in good self-care.
Your answers suggest that you are experiencing mild to moderate distress due to unusual experiences or behaviors.
We are glad you took a first step by taking this screening. Please remember that these results are not a diagnosis, but we do suggest follow up with a professional as a best next step.
SMH Screening for Mental Health


Your answers suggest that you are experiencing moderate or severe distress due to unusual experiences or behaviors.
Your answers also indicated that you might be at risk for suicide.
We are glad you took a first step by taking this screening and encourage you to seek additional support from a professional. Please remember that these results are not a diagnosis.
Please know that you are not alone. Reaching out for help is a big step and we encourage you to seek support as soon as possible. You can:
Chat live with someone from the National Suicide Prevention Lifeline (24/7)
Call 1-800-273-TALK (8255) for the National Suicide Prevention Lifeline (24/7)
Call 911
Go to your local crisis response center
Go immediately to the nearest hospital emergency room
SMH Screening for Mental Health


How have you been feeling lately?
Feeling sad, down, or empty
Depression: Community Screening
Depression: Clinical Screening
Constantly worried, anxious
Generalized Anxiety Disorder
Concerned about my teen's mood
Brief Screen for Adolescent Depression
Experiencing mood swings from very high to very low
Bipolar Disorder
Concerned about unusual experiences or behaviors
Psychosis: For Individuals
Psychosis: For Loved Ones
Worried about my drinking habits
Alcohol Use Disorder
Troubled by traumatic events
PostTraumatic Stress Disorder
Afraid of gaining weight or concerned about my eating habits
Eating Disorder
Difficulty controlling my substance use
Substance Use


They are uninterested in the things they used to enjoy.
True
False
How much discomfort has this experience caused:
None
Mild
Moderate
Severe

Your answers suggest that your friend/loved one is experiencing moderate or severe distress due to unusual experiences or behaviors.

We are glad you took a first step by taking this screening for your friend/loved one and encourage you to seek additional support from a professional for them. Please remember that these results are not a diagnosis.

Screening for Mental Health, Inc.

- MISSION: Providing innovative mental health and substance use education and screenings, linking those in need to quality treatment options.
- VISION: Envisioning a world where mental health is viewed and treated with the same gravity as physical health.

What we screen for: depression, bipolar disorder, posttraumatic stress disorder, generalized anxiety disorder, eating disorders, alcohol use disorders, substance use disorders, and adolescent depression

More than 650,000 screenings in 2015 alone

For more information

Candice Porter, LICSW
cporter@mentalhealthscreening.org

To preview the psychosis screening visit:
PsychosisAware.org

IT TAKES A COMMITTED CAMPUS:

SUPPORTING COLLEGE STUDENTS WITH MENTAL HEALTH CHALLENGES

Marsha Langer Ellison, Ph.D.

CEDAR: Responding to Risk for Psychosis Among College Students.
November, 2017

Acknowledgements

The Transitions Center aims to improve the supports for youth and young adults, ages 14-30, with serious mental health conditions who are trying to successfully complete their schooling and training and move into rewarding work lives. We are located at the University of Massachusetts Medical School, Worcester, MA, Department of Psychiatry, Systems & Psychosocial Advances Research Center.
Visit us at:

http://www.umassmed.edu/TransitionsRTC

The contents of this presentation were developed under a grant with funding from the National Institute on Disability, Independent Living, and Rehabilitation Research, and from the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services (ACL GRANT # 90RT5031, The Learning and Working During the Transition to Adulthood RRTC). NIDILRR is a Center within the Administration for Community Living (ACL), Department of Health and Human Services (HHS). Additional funding provided by UMass Medical School's Commonwealth Medicine division. The contents of this presentation do not necessarily represent the policy of NIDILRR, ACL, HHS, ASPE, and you should not assume endorsement by the Federal Government.


What is the problem?

- College attendance rates among student samples with SMHC range from 7% - 26% compared to 40% for the general population. [1,2]
- Students with mental health conditions who attend college experience longer delays in entering college [3] and have high dropout rates. [4]

The American College Health Association 2006 survey reports that [5]
(94,806 students from public and private universities across the country)

Within the past year:
94 out of 100 students reported feeling overwhelmed by all they had to do.
44 out of 100 - almost half - have felt so depressed it was difficult to function.
8 out of a 100 reported having a depressive disorder.
12 out of 100 had an anxiety disorder.
9 out of 100 reported having seriously considered suicide within the past year.
1.3% actually did attempt suicide.

Social Model of Disability

The problem does not lie with the individual;
but rather with the:

- Disabling environment
- Negative attitudes
- Barriers
- Discrimination

WHAT DOES IT TAKE?

Environmental Approaches to Supporting Students with Mental Health Conditions.

PROTECT RIGHTS

Your Mind. Your Rights. Campus Mental Health: Know Your Rights. A guide for students who want to seek help for mental illness or emotional distress.

http://www.bazelon.org/Portals/0/pdf/YourMind-YourRights.pdf

My Mental Health Rights on Campus

http://umassmed.edu/transitionsRTC/publication

SUPPORTIVE POLICIES

A MODEL POLICY FOR COLLEGES AND UNIVERSITIES

Bazelon Center for Mental Health Law

Guiding Principles
- Acknowledge but not stigmatize mental health conditions
- Make suicide prevention a priority
- Ensure that personal information is kept confidential
- Provide reasonable accommodations
- Refrain from discrimination against students with mental health conditions; including punitive actions toward those in crisis
- Encourage help-seeking

http://www.bazelon.org/pdf/SupportingStudents.pdf

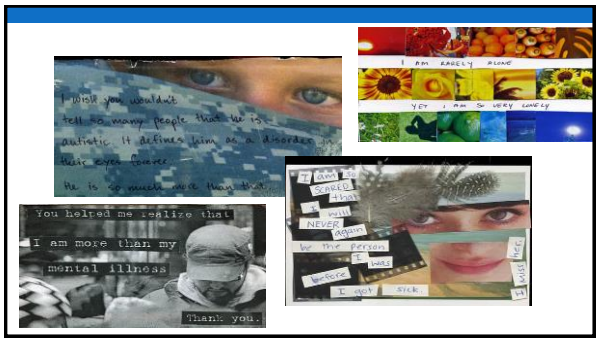
INCREASE AWARENESS

Send Silence Packing

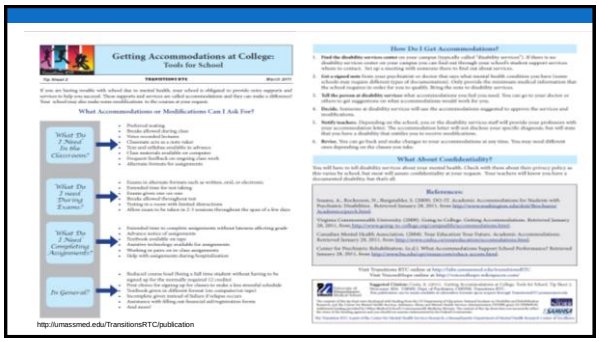
First hand accounts and resources

http://sendsilencepacking.org/

1,100 bags =
1 bag to represent every student who dies
each year by suicide



EDUCATIONAL ACCOMMODATIONS



Accommodations for Students with Mental Health Conditions

- Exam individually proctored, including in the hospital
- Modified or preferential seating arrangements
- Substitute assignments in specific circumstances
- Extended time for assignments and test taking.
- Provision of Incomplete (I) grade rather than a Failure (F) if relapse occurred
- Written assignments instead of oral presentations, or vice verse
- Permission to submit assignments handwritten rather than typed

Rated "extremely helpful" by a majority of students with mental health conditions in a national survey. [6]

"Outside the box" accommodation considerations:
time to "pre-process" what's ahead
allow for missed classes
broken time instead of extended time
reduce "on demand" responses
reframe and clarify questions[8]

STUDENT MOVEMENTS

Peer Support

"changing the conversation about mental health"

active minds

Educate students so they know where to turn for help
Empower students to engage peers, administrators and communities on every campus
Teach student leaders to ensure the next generation of advocates
Connect all who are passionate about college mental health

Alison Malmon, Founder of Active Minds

http://www.activeminds.org/

FACILITATE HELP-SEEKING

Student Support Network

- Gatekeeper model for suicide prevention
- Training and using natural college networks and peers
  - Residence monitors
  - Sororities/Fraternities
  - Clubs
  - Sports, coaches

Goals: (1) enhancing knowledge of mental health conditions,
(2) promoting skill development in core helping skills,
(3) reducing stigma associated with help seeking
(4) enhancing connection with key campus resources

Key knowledge areas addressed:
(1) understanding elements of "good" mental health
(2) knowing signs of depression, anxiety, and substance abuse
(3) accessing local helping resources
(4) determining level of concern with friends who are in distress

Daniel J. Kirsch,D., & Stephanie L. Pinder-Amaker, S., Morse, C., Ellison, M., Doerfler, A.,& Riba, B. (2014). Population-Based Initiatives in College Mental Health: Students Helping Students to Overcome Obstacles. *Current Psychiatry Reports, 16*:525

A COMPREHENSIVE APPROACH

JED "Comprehensive Approach"

http://www.jedfoundation.org/professionals/comprehensive-approach

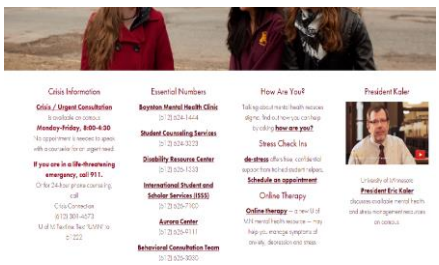
NAMI On Campus

National Alliance on Mental Illness

- There are 125+ NAMI on Campus clubs
  Goals are to:
- Promote early detection
- Provide intervention and resources
- Encourage students to get help
- Combat stigma
- End seclusion of college students with mental health conditions
- Promote existing services
- Advocate for enhanced supports

http://www.nami.org/Find-Support/NAMI-Programs/NAMI-on-Campus

UMinn Mental Health Resources Website



What does a committed campus take?

- Commitment!
- Multi-faceted approach
  - Policies
  - Rights
  - Awareness
  - Accommodations
  - Peer support
  - Academic support
  - Departmental collaboration

References

1. Wagner, M., Newman, L. (2012). Longitudinal transition outcomes of youth with emotional disturbances. Psychiatric Rehabilitation Journal, 35, (3), 199-208.
2. Davis, M., & Vander Stoep, A. (1997). The transition to adulthood for youth who have serious emotional disturbance: Developmental transition and young adult outcomes. *The Journal of Behavioral Health Services and Research, 24, (4),* 400-427.
3. Newman, L., Wagner, M., Knokey, A.-M., Marder, C., Nagle, K., Shaver, D., Wei, X., with Cameto, R., Contreras, E., Ferguson, K., Greene, S., and Schwarting, M. (2011). *The Post-High School Outcomes of Young Adults with Disabilities up to 8 Years After High School. A Report From the National Longitudinal Transition Study-2 (NLTS2)* (NCSER 2011-3005). Menlo Park, CA: SRI International. Available at www.nlts2.orgreports/
4. Salzer MS, Wick LC, & Rogers JA. (2008) Familiarity with and use of accommodations and supports among postsecondary students with mental illnesses. *Psychiatric Services*; 59(4):370-375.
5. American College Health Association. (2007). American college health association national college health assessment spring 2006 reference group data report (abridged). Journal of American College Health, 55(4), 195.
6. M. Salzer. (2012) Addressing Environmental Barriers Affecting Retention and Performance of College Students Who Experience Psychiatric Disabilities, Presentation to the 2012 National Transition Conference, Washington DC
7. Ringeisen, H., Ryder-Burge, A., Ellison, M., Biebel, K. Alikhan, S. (2015). Feasibility Study for Demonstration of Supported Employment to Promote Educational Attainment and Employment among Individuals with Serious Mental Illness. NC, RTI Int'l. Available at http://www.umassmed.edu/TransitionRTC/publications
8. DiGalbo, L., Logan, D., Duperoy, T. & Smith, T. (2017). Outside-The-Box Accommodations: Real Support for Real Students, Tools for School II. Worcester, MA: University of Massachusetts Medical School, Department of Psychiatry, Systems and Psychosocial Advances Research Center (SPARC), Transitions Research and Training Center.

Wrap-up

Get materials and products on the Transitions RTC website. Sign up on our list serve.

http://www.umassmed.edu/TransitionsRTC/

Register for exciting webinar on educational accommodations for college students with mental health conditions. Tuesday, May 3rd 12N. 2016

Contact Us!

Marsha.Ellison@umassmed.edu

Responding to Risk for Psychosis Among College Students:
Innovative Programming

Dori S. Hutchinson, Sc.D., CPRP, CFRP
Center for Psychiatric Rehabilitation
Boston University

The Hub:
Innovative Programming for Collegiate Mental Health & Academic Success

- **NITEO**
- **NITEO Activities**
- **Peer Mentoring**
- **LEAD BU**
- **College Coaching**
- **Training & Consulting**
- **Advocacy**
- **Community Building**

With Gratitude for Funding from the Sidney Baer Foundation

NITEO: "*thrive, bloom*"

- 15 hr week/1 semester program for ANY college student with serious mental health condition
- Simulated higher education academic environment: classroom and coaching.
- Focus on critical skills and supports for return to school or work.

SKILLS:

- problem-solving
- social skills (peer mentors)
- time management
- Wellness and resilience
- Mindfulness & Artistic Expression
- Self-Advocacy and Shame resistance
- Academic persistence
- Cognitive remediation
- Presentation and test-taking
- Writing skills

NITEO Program Evaluation

- Demographics N=78
- 59% male, 36% female, 5% other
- 25% psychotic disorder
- 51% mood disorder
- 12% anxiety
- 7% PTSD
- 5% Substance Abuse
- Mean age=20.8 years
- 21% were enrolled in some form of education at intake-part-time enrollment.

- Methods:
  - Objective and subjective effects
  - Assessed at intake and 15 weeks.
  - Subjective self-report measures:
    - Mental Health Inventory
    - Self-Efficacy for Learning Form
    - Adult Hope Scale
    - Domain Specific Hope Scale
  - Objective self report measures:
    - School engagement (PT/FT)
    - Work Status (PT/FT)

OUTCOMES

- School Engagement post program: 68%
- Work Engagement: 44%
- A combined total of 83 % of NITEO students were involved in either work or school at the end of 15 weeks.
- Mixed effects models:
  - Psychiatric DX was NOT a significant predictor for return to school.
  - Positive Affect and Changes in Emotional ties were predictive indicators of participation in Higher ed.
  - Psychiatric Dx was a predictor of work participation.

- Significant Increases in:
  - Positive affect (P<.001)
  - Emotional ties (p<.005)
  - Life satisfaction (p<.001)
  - Global mental health (p<.001)
  - Academic Self-Efficacy (p<.002)
  - Overall hopefulness (p<.001)
- Significant decreases in:
  - Anxiety (p<.001)
  - Depression (p<.001)
  - Loss of control (p<.001)
  - Psychological distress (p<.001)

Application Process

- Application packet:
- https://cpr.bu.edu/living-well/college
- Two interviews and tours with Staff: Cjoly@bu.edu
- Student-led readiness assessment
  - goals & needs
  - housing
  - resources
- Timely integration to services: Need based Financial Aid.
- **No exclusion criteria based on**
  - diagnosis or history of substance use
  - cognitive impairment
  - current supports/treatment

BOSTON UNIVERSITY

THE 99 FACES PROJECT

PORTRAITS WITHOUT LABELS

portraits of courageous individuals and the incredible people who love them

THE 99 FACES PROJECT

33 people living with bipolar disorder

33 people living with schizophrenia

33 people who love them

THE 99 FACES PROJECT

PORTRAITS WITHOUT LABELS

179

LUNCH BREAK!

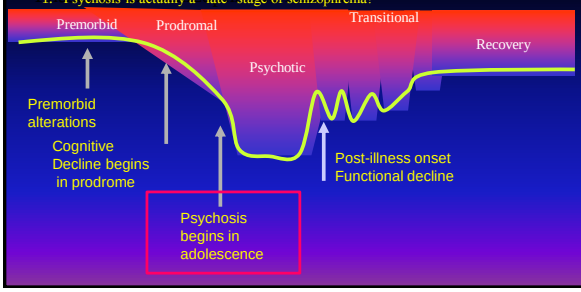
Neurobiology of Early Psychosis, Brain Plasticity, and Rationale for Early Intervention

Matcheri S. Keshavan, MD
Harvard Medical School
Beth Israel Deaconess Medical Center and Massachusetts Mental Health Center

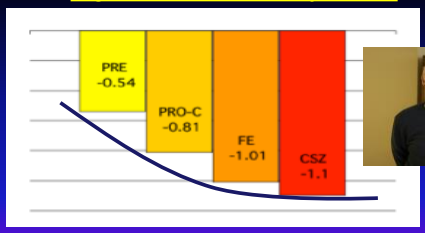
Supported by Department of Mental Health, Massachusetts, NIMH, Baer and Natalia Foundation
Other relevant disclosures: Chief Editor, Schizophrenia Research

TEN reasons for WHY intervene early in someone at risk for Psychosis

1. Psychosis is actually a "late" stage of schizophrenia!

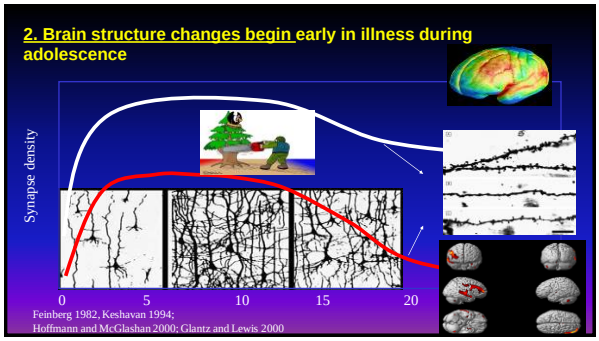


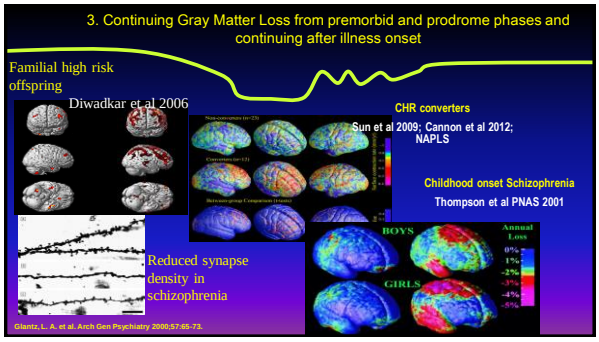
Cognitive decline occurs early in illness

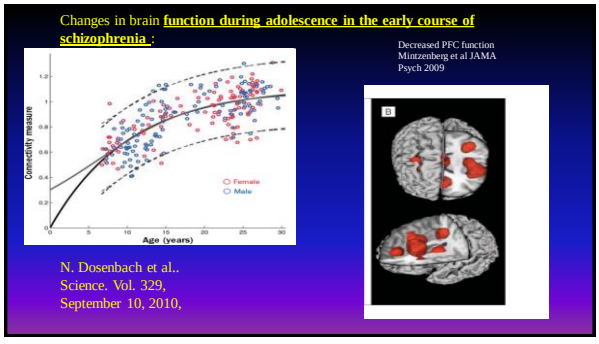


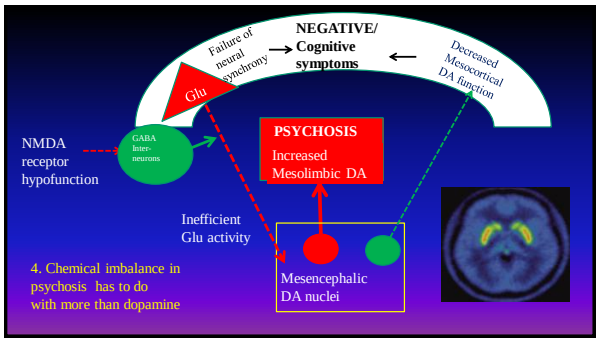
Lu, Keshavan, Tronick and Seidman Schizophr Bull 2015;41:801-816

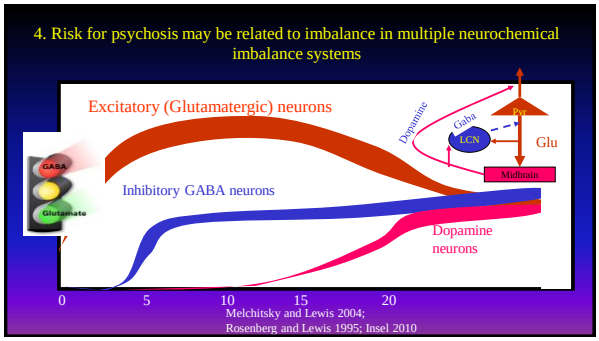
Schizophrenia Bulletin

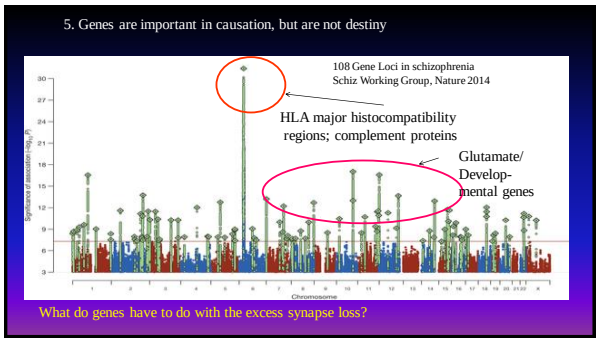

2. Brain structure changes begin early in illness during adolescence
Synapse density
0
5
10
15
20
Feinberg 1982, Keshavan 1994;
Hoffmann and McGlashan 2000; Glantz and Lewis 2000

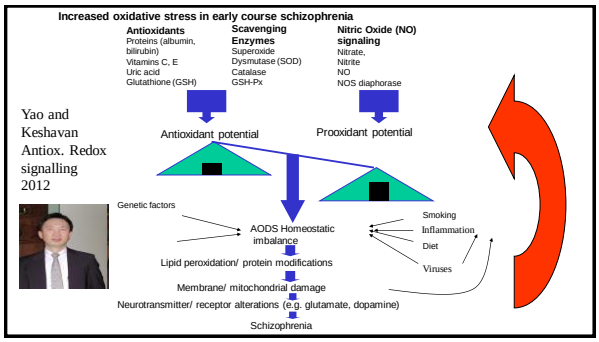

3. Continuing Gray Matter Loss from premorbid and prodrome phases and continuing after illness onset
Familial high risk offspring
Diwadkar et al 2006
CHR converters
Sun et al 2009; Cannon et al 2012; NAPLS
Childhood onset Schizophrenia
Thompson et al PNAS 2001
BOYS
GIRLS
Annual Loss
Reduced synapse density in schizophrenia
Glantz, L. A. et al. Arch Gen Psychiatry 2000;57:65-73.


Changes in brain function during adolescence in the early course of schizophrenia ;
Connectivity measure
Age (years)
Female
Male
N. Dosenbach et al..
Science. Vol. 329,
September 10, 2010,
Decreased PFC function
Mintzenberg et al JAMA Psych 2009

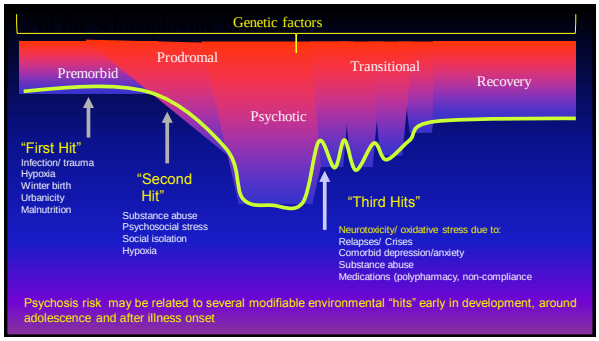

NEGATIVE/
Cognitive
symptoms
Failure of
neural
synchrony
Decreased
Mesocortical
DA function
Glu
NMDA
receptor
hypofunction
GABA
Inter-
neurons
PSYCHOSIS
Increased
Mesolimbic DA
Inefficient
Glu activity
Mesencephalic
DA nuclei
4. Chemical imbalance in
psychosis has to do
with more than dopamine

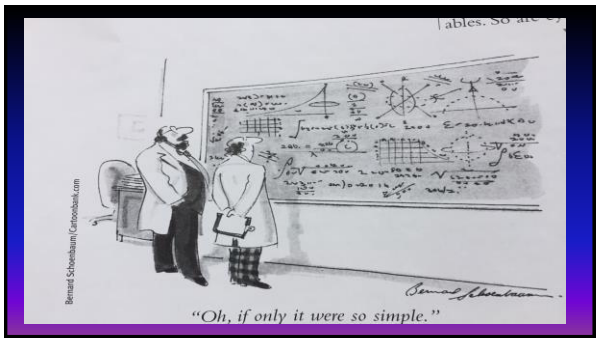

4. Risk for psychosis may be related to imbalance in multiple neurochemical imbalance systems
Excitatory (Glutamatergic) neurons
Inhibitory GABA neurons
Dopamine
neurons
Dopamine
Gaba
LCN
Pyr
Glu
Midbrain
GABA
Glutamate
0
5
10
15
20
Melchitsky and Lewis 2004;
Rosenberg and Lewis 1995; Insel 2010


5. Genes are important in causation, but are not destiny
108 Gene Loci in schizophrenia
Schiz Working Group, Nature 2014
HLA major histocompatibility
regions; complement proteins
Glutamate/
Develop-
mental genes
Chromosome
What do genes have to do with the excess synapse loss?

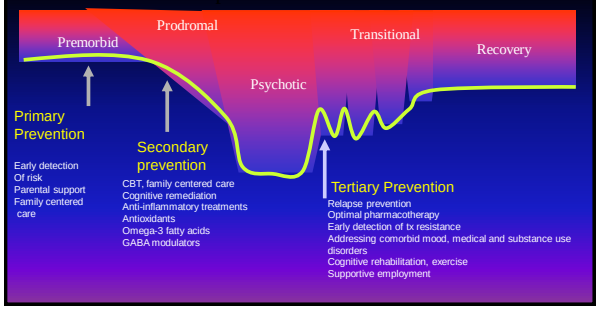


Yao and Keshavan Antiox. Redox signalling 2012





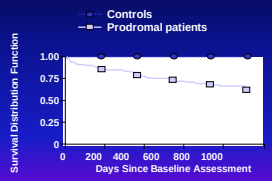
6. Several hypothesis- driven interventions now available for early intervention & prevention



7. We now have better ways to PREDICT psychosis and its aftermaths

PRODROME CAN BE PROSPECTIVELY DEFINED AND IS ASSOCIATED WITH SIGNIFICANT RISK OF CONVERSION

- OUTCOMES
  - Risk of conversion 35% during f/u period
  - 5 clinical features improved prediction: "genetic" risk for schizophrenia + deterioration, higher severity of unusual thought content, suspicion/paranoia, greater social impairment, history of substance abuse

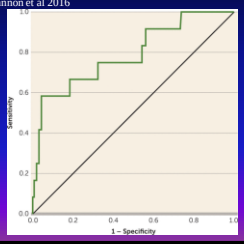


North American Prodrome Longitudinal Study (NAPLS)

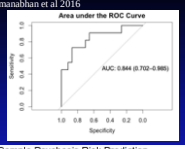
Cannon TD, et al. *Arch Gen Psychiatry*. 2008;65:28-37.

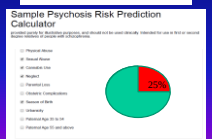
Cumulative survival distribution function modeling time to conversion to psychosis in 291 clinical high-risk (prodromal) patients and 134 demographically comparable normal control subjects (dashed line).

Risk calculator predicts conversion to psychosis in Clinical high risk individuals
Cannon et al 2016



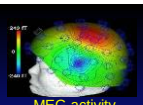
Polyenvirome risk score predicts conversion to psychosis in Familial high risk individuals
Padmanabhan et al 2016





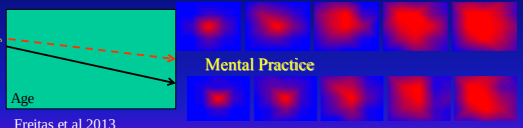
https://kesh-lab.shinyapps.io/PERS-calc

8. Younger brains have more brain plasticity



Physical Practice

MEG activity
Motor cortex

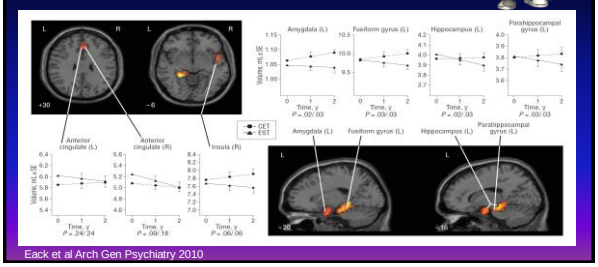


Freitas et al 2013

Day 1 2 3 4 5

Pascual-Leone et al. JNP 94

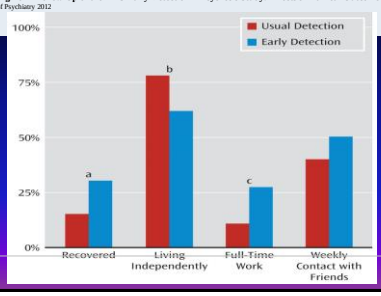
9. Psychosocial treatments can Harness brain plasticity early in those at risk to protect against gray matter loss, and to build "reserve"



Eack et al Arch Gen Psychiatry 2010

10. Early detection improves long term outcome

From: Long-Term Follow-Up of the TIPS Early Detection in Psychosis Study: Effects on 10-Year Outcome McGlashan TH et al American Journal of Psychiatry 2012



Ten reasons why early intervention is critically important in psychoses

- Psychosis BEGINS IN ADOLESCENCE but schizophrenia begins at, or before birth
- Cognitive and negative symptoms deficits begin long before psychosis, and underlie the substantive disability
- Alterations in brain structure and function are present early, and before symptoms begin
- The longer the illness remains untreated, the worse is the outcome
- Psychoses are caused by MODIFIABLE genes and environmental factors
- There are now many more TARGETS FOR INTERVENTION, not just dopamine excess!
- We now have better ways to PREDICT psychosis and its aftermaths
- Brain can build and repair itself
- PLASTICITY early in life can be harnessed to improve outcome and reverse brain loss
- Early detection (Shortening DUP) improves outcome

Tandon, Keshavan and Nasrallah Schiz Res 2008; 2010; 2012

Expansion of Early Psychosis Efforts in MA

MARGARET GUYER, PHD
DIRECTOR, FIRST EPISODE PSYCHOSIS INITIATIVE
DEPARTMENT OF MENTAL HEALTH (DMH)

"Let Me Understand"

Talking with Youth and Families about Psychosis Risk

Jeanne Haley, MSW, LICSW
Kristen Woodberry, MSW, Ph.D.

Talking with Students and Families at a College Counseling Center about Psychosis

Jeanne Haley, LICSW
Counseling Center
Framingham State University

Overlap of symptoms

- Common presenting concerns at College Counseling Center

- Mood Disorder
- Trauma
- Substance Misuse
- Sleep issues

When is there more to explore?

- Common causes of psychosis

- Mood disorder
- Trauma
- Substance Related
- Primary Thought Disorder

How do students accommodate and function so we don't always look further?

CASE 1

22 y.o. student with history of trauma. She began to increase alcohol use to "help manage the bad thoughts." She began to report that she was losing time and was worried she was slowly losing her mind. She was asked what kind of bad thoughts she was having.

- "I sleep with a knife under my pillow to protect myself because I think someone will try to get me."

"Have you ever had to take the knife out because you thought someone was in your room?" (yes)
"Did you realize there was no one in the room?" (yes)

- "I can't pay attention in class because I have violent day dreams. I see myself choking someone."

"Do you know if this is really happening or not?" (No)
"Do you understand these experiences as hallucinations?" (yes)

Counselor: "What do you do to manage what is happening?"

- "I bite my lips and side of my mouth, so I don't scream or say anything inappropriate."
- "I drink so I don't have to deal with it. At least I get a little break from it."
- "I wonder what is wrong with my brain?"

- "Have you ever told anyone else about this?" (yes, my mom. She thinks I do it because my Dad was abusive.)
- "Do you think the abuse is the reason for these experiences? Do you think it explains what is happening to you?" (No)
- "Your brain is experiencing things that are not real. It may be a psychotic process."

Case2

18 y.o. student with history of anxiety. She presented with insomnia. She reports she can not sleep in a dorm room with anyone else as she "hears every sound and is very sensitive." She reports history of "seeing things" at her home, but her family believes there are ghosts in the house.

- "I see things at my house that aren't there. But, my family believes in ghosts."
  - "Do you see things in other places that aren't there?" (yes, at the mall, at my boyfriends' house). "Do you think there are ghosts in these other places?" (I don't know).
- "I heard voices outside my dorm room. I stayed up all night to try to hear what they would say."
  - "Do you think there was someone outside your room?" (I don't think so.)
  - "Do you think something else is going on..is your brain hearing things that aren't there? (I think so)

Counselor: "What do you do to help manage what is happening?"

- "When I thought someone was breaking in to my house, I taped plastic bags on all the windows so they couldn't get in."
  - "Did you know if someone was actually trying to break in or not?" (I don't think anyone was really there.) "Could you talk to your parents about what was going on?" (no, they think I am very sensitive and anxious.)
- "Is there something wrong with my brain? Not everyone has these weird thoughts."
  - "Your brain is registering sounds and things that are not there. You are accurate that not everyone has these thoughts and experiences. It sounds like they are hallucinations." "What do you think about that word, hallucination?" (I think they are hallucinations.)

Family Meetings

- Validate their experience, AND, expand on it. Explain that the students' symptoms are **more** than what we would see in someone with anxiety, trauma, or homesickness.
- Discuss family beliefs that support the symptoms.

In the first case example, the parent thought family abuse/trauma was the reason for the daughter sleeping with a knife. In the second case, the family thought that ghosts were in the house, which explain seeing and hearing things. **Elaborate on the experiences their child has been having that do not fit into this narrative.**

- Discuss need for broader assessment of symptoms. Include: medical evaluation, further family history of mental health issues, gathering data about length of symptoms, and other testing.

Family meetings

- Education about treatment options and supports available. Discuss the benefits of early intervention and treatment.
- Tell the family how their child reacted to discussion about psychosis.

"What a relief it is to know what is going on."
"I don't want to keep feeling this way by myself."
"I want to feel better."

"Let Me Understand"

Talking with Youth and Families about Psychosis Risk

Kristen Woodberry, MSW, Ph.D.

CEDAR is Here to help!

- We can help you talk with youth & families.
- Call us when you are with them.
- Get a signed release.
- Check out our family-friendly handouts:
  http://cedarclinic.org/index.php/all-news/181-handouts-for-understanding-and-managing-psychosis

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BELIEVE IN YOUR POWER TO AFFECT CHANGE

Understanding Psychosis

A person experiencing psychosis is often confused and frightened. He is doing his best to make sense of and manage his own thoughts and perceptions. He may be trying to protect himself.

Consider:

- Psychosis involves a **brain-based** difficulty telling what is real from what is not real.
- *Core symptoms* are:
  - ***Hallucinations:*** false perceptions, seeing or hearing things others do not.
  - ***Delusions:*** false, often odd or irrational, beliefs
  - ***Confused Thinking or Speech:*** thoughts get tangled or jump around illogically
- It involves a **difficulty filtering** out important from background information. As a result, a person may be sensitive to bright lights, noise, conflict, complexity, changes in routine, or street drugs. She may feel **easily overwhelmed**, confuse the sound of the heating system for mumbled voices, be highly distractible, irritable, or just want to stay in bed.
- The person's psychosis is **only one part of her experience**. She is a whole person with a unique history, set of preferences, personality traits, capabilities, hopes and dreams.

Strategies

- Look for quiet opportunities when the person is less overwhelmed to approach him.
- Keep communication simple. Speak in short sentences. Ask one question at a time.
- Ask about the person's interests as well as his experience of symptoms or problems.
- Listen to his values, goals, worries, and frustrations.
- Ask him to tell you what his experience is: what is it like to get up, go out of the house, be at school, or with friends, sitting in front of his homework, or answering questions.
- Watch for what is stressful or overwhelming, calming or manageable.
- Look together at websites, movies, or informational pamphlets about psychosis.

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BELIEVE IN YOUR POWER TO AFFECT CHANGE

A tool for families – to support (but not replace) good clinical care

Helping a Youth Who Sees or Hears Things that are not Real

Listen. You may reassure her that her perceptions are not real, but **do not argue.** Attend to her ***feelings*** about the experiences. Help her manage these.

Consider:

- Does your loved one have a sense that what he is experiencing may not be real?
- Are the experiences **positive** (comforting, kind, interesting) or **distressing** (critical, threatening, scary), or both?
- Is your loved one open to talking about his unusual perceptions?
- Perceptual abnormalities, like other symptoms, are made **worse by stress.**
- **Substance use/abuse** can cause or increase hallucinations.
- **Medications** may help and may need to be increased during times of stress.
- Each person's experience is **unique**. Take time to find out what is helpful to your loved one.
- **Work closely with a clinician** to come up with strategies. Adjust them as needed.

Possible Strategies:

- Establish and maintain **predictable, low stress routines** with reduced expectations.
- See if it helps to **relax**, take deep breaths, find quiet. Have her try closing her eyes.
- Or if it helps to **get busy**, exercise, listen to loud music, or engage in a game or task.
- See if blocking her ears or **wearing headphones** helps.
- How about doing something **social** with friends or family? A game, a movie, or talking.
- See if telling the voices to **"Stop" or "Go Away"** helps.
- Teach her to self-talk: **"Take it Easy" or "I can handle it" "I don't have to listen."**
- Make a list of **different strategies** to try. Have him pick a couple to start with.
- Accept, let the perceptions come and go. Continue with other parts of life: school, work, play.

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BELIEVE IN YOUR POWER TO AFFECT CHANGE

A tool for families – to support (but not replace) good clinical care

Family Guidelines for Helping a Young Person with Psychosis

Families can play a powerful role in supporting recovery, reducing stress, and helping to prevent the onset or worsening of symptoms.

Consider:

- Psychotic illnesses are influenced by **both biological and environmental factors.**
- Reducing stress within family relationships, schedules, and daily interactions can make it easier for someone with psychosis to manage day-to-day life.
- Family support can also provide a buffer against outside stressors.
- *People experiencing psychosis may be particularly sensitive to the following:*
  - ***Warmth, structure, support, space:*** help them recover at their own pace
  - ***Criticism:*** negative comments and interactions can lead to increased symptoms
  - ***Over-involvement:*** intrusiveness or doing too much can overwhelm people
  - ***Complex, unclear communication:*** is hard to process and can worsen symptoms

Guidelines:

- ***Take one step at a time.*** Go slow. Progress may be gradual. Recovery takes time.
- ***Lower expectations for the short term.*** Compare this month to last month rather than last year. Increase expectations only after a period of improvement or stability.
- ***Use symptoms as a guide.*** If they worsen, slow down, simplify, reach out, and ask for more professional help. If they improve, continue forward gradually.
- ***Know and watch for early warning signs.*** If you notice subtle changes in behavior or increases in symptoms, slow down or take a break. Ask for help early, when a little may go a long way.
- ***Keep it cool.*** Enthusiasm is normal. Disagreement is normal. *Just tone it down.*
- ***Give each other space.*** It's okay to offer. It's okay to refuse.

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Helping a Young Person with Low Motivation

Your child is not lazy. This is a symptom. She may need more frequent and powerful rewards. Reward small steps in the right direction.

Consider:

- A lack of motivation in the context of mental illness is often linked to decreased activity in the areas of the brain responsible for initiative, anticipation of reward, and experience of pleasure.
- What does your loved one enjoy doing? Is there anything he does without prompting?
- Are there privileges or items your loved one wants to buy? Places she wants to go?
- Is your loved one feeling sad or depressed? Anxious? These can also reduce motivation.
- How much time does she spend alone, playing online games, watching movies?
- Substance use/abuse can make the lack of motivation worse.
- Stress may decrease motivation. Is your loved one overwhelmed? Feeling incompetent?
- Is she getting enough sleep?
- Is his medication dose too high?
- Each person's experience is unique.
- Work with your loved one, his doctor and/or clinician to find what is most helpful to him.

Possible Strategies:

- Work with your child, school personnel, and others to consider how different types and levels of stimulation impact her motivation. Experiment. Ask your child what helps.
- Establish and maintain predictable, low stress, but highly structured routines. Your loved one may be able to *do* things that are routine, even if they do not *feel* motivated.
- Help her get started. Sometimes that's all a person needs.
- Break big tasks into small ones. If this doesn't work, break them down further.
- Make a daily to-do list of very small tasks. Have your loved one cross off items when done.
- See if doing something like homework with someone is easier. Social support can motivate.

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BELIEVE IN YOUR POWER TO AFFECT CHANGE

A tool for families – to support (but not replace) good clinical care

Helping a Young Person who is Losing Touch with Reality

Listen. You will be more helpful if you **understand** your child's experience and **avoid a power struggle.** Attend to her ***feelings, interests, and goals.***

Consider:

- Each person's experience is **unique.** Take care to find what is helpful to your loved one.
- Does your loved one recognize that she's losing touch with reality?
- Is your loved one's experience positive (empowering, an escape), distracting (keeping him from relating to others or going to school) and/or distressing (confusing, overwhelming, scary)?
- Is your loved one open to talking about what's going on?
- How much time does your loved one spend alone, playing online games, watching movies?
- Substance use/abuse can make the loss of reality worse.
- Medications may help and doses may need to be increased during times of stress.
- Discuss treatment options with your loved one's doctor and/or clinician.

Possible Strategies:

- Work with your child, school personnel, and others to minimize time alone or engaged with fantasy material (e.g., online role playing games, movies). You may have to gradually reduce the time your child is allowed to engage in these activities.
- Establish and maintain predictable, low stress, but highly structured routines.
- See if it helps to engage in an activity, a game or project, to exercise or listen to music.
- Try doing a very simple task that requires attention to the current context, e.g., a counting things in the room that are a given color, then another color, etc.
- How about doing something social with friends or family? A game, a project, or talking.

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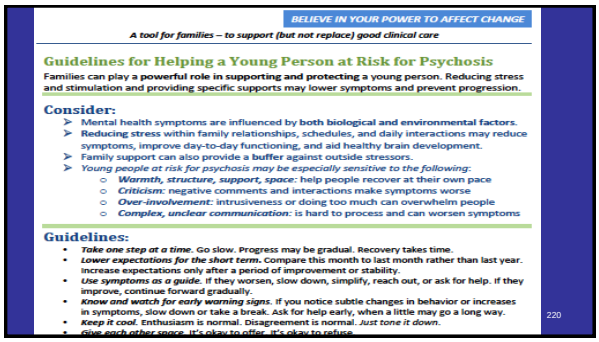

BELIEVE IN YOUR POWER TO AFFECT CHANGE

A tool for families – to support (but not replace) good clinical care

Guidelines for Helping a Young Person at Risk for Psychosis

Families can play a powerful role in supporting and protecting a young person. Reducing stress and stimulation and providing specific supports may lower symptoms and prevent progression.

Consider:

- Mental health symptoms are influenced by **both biological and environmental factors**.
- Reducing stress within family relationships, schedules, and daily interactions may reduce symptoms, improve day-to-day functioning, and aid healthy brain development.
- Family support can also provide a **buffer** against outside stressors.
- *Young people at risk for psychosis may be especially sensitive to the following:*
  - ***Warmth, structure, support, space:*** help people recover at their own pace
  - ***Criticism:*** negative comments and interactions make symptoms worse
  - ***Over-involvement:*** intrusiveness or doing too much can overwhelm people
  - ***Complex, unclear communication:*** is hard to process and can worsen symptoms

Guidelines:

- ***Take one step at a time.*** Go slow. Progress may be gradual. Recovery takes time.
- ***Lower expectations for the short term.*** Compare this month to last month rather than last year. Increase expectations only after a period of improvement or stability.
- ***Use symptoms as a guide.*** If they worsen, slow down, simplify, reach out, or ask for help. If they improve, continue forward gradually.
- ***Know and watch for early warning signs.*** If you notice subtle changes in behavior or increases in symptoms, slow down or take a break. Ask for help early, when a little may go a long way.
- ***Keep it cool.*** Enthusiasm is normal. Disagreement is normal. *Just tone it down.*
- ***Give each other space.*** It's okay to offer, it's okay to refuse.

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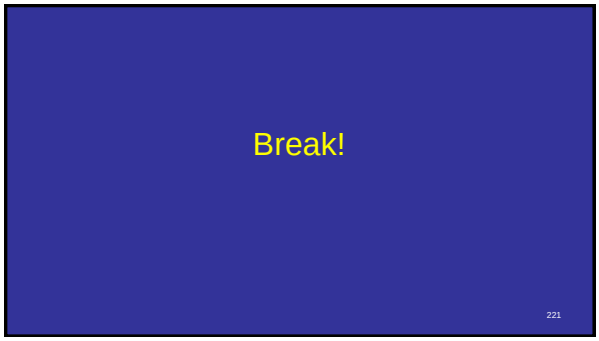

Break!

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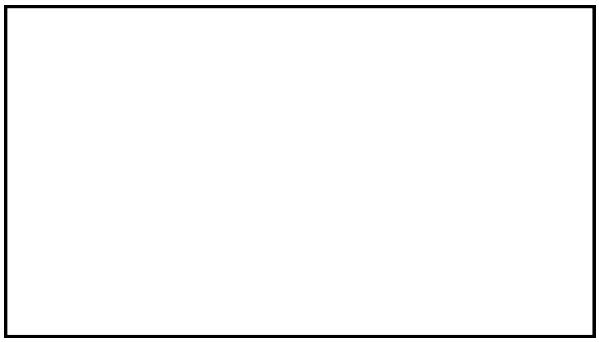


Panel: Local Treatment Innovations

WILLIAM STONE, PHD
KRISTEN WOODBERRY, PHD
MICHELLE FRIEDMAN-YAKOOBIAN, PHD.

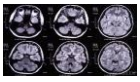
North American Prodrome Longitudinal Study (NAPLS-3)

William B. Stone, PhD
Primary Investigator, Harvard Site
NAPLS Study
Disclosures: Funding for this work comes from the National Institute of Health (NIH)

North American Prodrome Longitudinal Study (NAPLS-3)

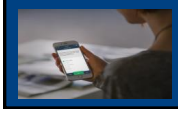
- 2-year monitoring/assessment study for people ages 12-30 experiencing possible risk for psychosis
- Investigates brain structure, biological data, clinical variables, cognition, and functioning
- Participants eligible for short-term individual therapy (psychoeducation & skills)





Exploring the Everyday Dynamics of Affect, Psychosis, Risk and Social Context

Kristen Woodberry, MSW, PhD
Program for Psychosocial Protective Mechanisms
Commonwealth Research Center
kwoodber@bidmc.harvard.edu



Disclosures

Funding for this work comes from:

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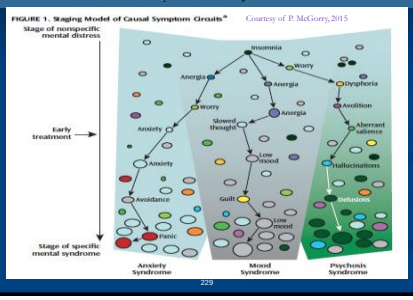
MA DMH SCDMH82101008006

Developmental Trajectories



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NIH Strategic Objective 2

"chart mental illness trajectories to determine when, where, and how to intervene"

including

"behavioral indicators that predict change across the [developmental] trajectory of illness."

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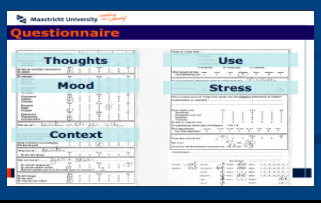
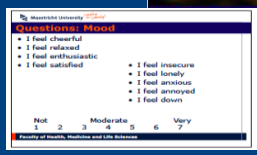
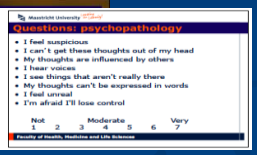
Capturing Change *As It Occurs*

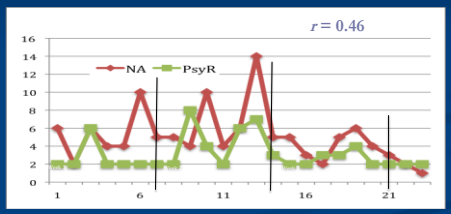


Sample Items



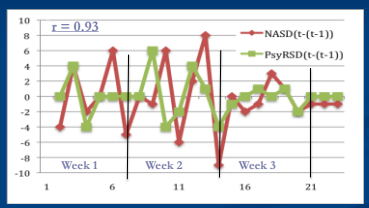


Examining Affect and Psychotic Symptoms in Daily Life



Negative Affect: Anxiety and Irritability
Psychotic Symptoms: Voices and Visual Disturbances

Changes in Affect and Psychosis



weekly NA variability (MSSD) and mean Psy are very highly correlated

A Multisite Study coming soon…


Kelsey Johnson


Doug Robbins, MD


Sarah Lynch, MSW

CLUES: Cognition for Learning and for Understanding Everyday Social Situations

SOCIAL AND COGNITIVE TRAINING FOR INDIVIDUALS AT CLINICAL HIGH RISK (CHR) FOR PSYCHOSIS

Michelle Friedman-Yakoobian PhD

Funding: Sidney R. Baer, Jr. Foundation; Commonwealth Research Center, Massachusetts Dept of Mental Health; NIMH 1R34MH105596

237237

CLUES: Cognition for Learning & Understanding Everyday Social Situations

- Targets attention, thinking, memory, & social wisdom
- Ages 15-30
- Intensive treatment program based on cognitive enhancement therapy (Hogarty et al., 2004)
  - Cognitive enhancement in pairs
  - Group-based education & social skill-building
  - Individual coaching and treatment planning
- Incorporates acceptance & commitment therapy (ACT)
- Study is comparing CLUES package to ACT intervention including individual and group components + online trivia game

CLUES Overview

Assessment (baseline and following CLUES)	Cognitive style Neuro and social cognition Social and role fx Clinical high risk symptoms Confidence in cognition
Computerized cognitive training	Weekly paired sessions with coach
	Web-based training at home or in lab
Individual coaching	Weekly individualized sessions
CLUES Course	22-session social-cognitive group
Family involvement	Family information session Family coaching sessions 1x per month

Clues R34 Study

(Keshavan PI)

- Phase I: Protocol and manual development
- Phase II: Open-label CLUES group for feasibility
- Phase III: Randomized Control Trial of CLUES vs. ACT for CHR

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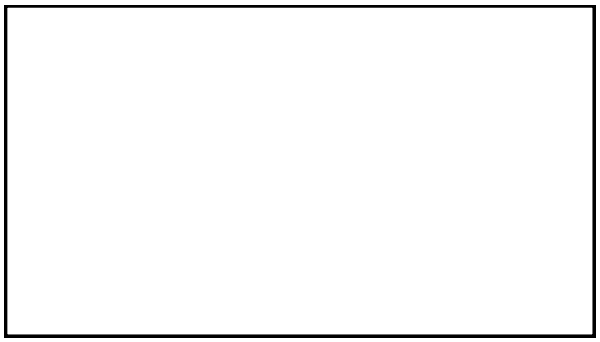
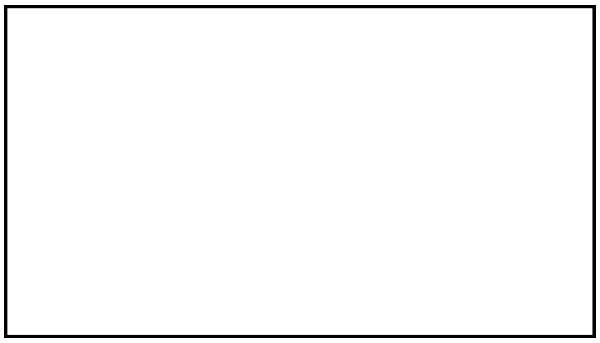



The Right Help at the Right Time
DAN



Interventions for Youth at Risk for Psychosis

Michelle Friedman-Yakoobian, Ph.D.
Suzannah Zimmet, MD

www.cedarclinic.org

Supported by the Massachusetts Department of Mental Health, the Baer Foundation National Institute of Mental Health (Grant #1R34MH105596), and an Anonymous Foundation with no direct financial interest in this work

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Interventions for Youth at Risk for Psychosis

- Benefits of early treatment
- Emerging treatment evidence
- Treatment at CEDAR Clinic
  - Overview
  - Case example
  - Psychiatry and health management
  - Psychoeducation / CBT and acceptance based treatment tools

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Rationale for Early Intervention

- Greatest deterioration first 2 years
- Possible brain deterioration / synaptic pruning in early stages of psychosis
- Losses in social and role functioning
- Early detection predicts better outcome

Early treatment can relieve suffering, prevent disability, and possibly prevent psychosis

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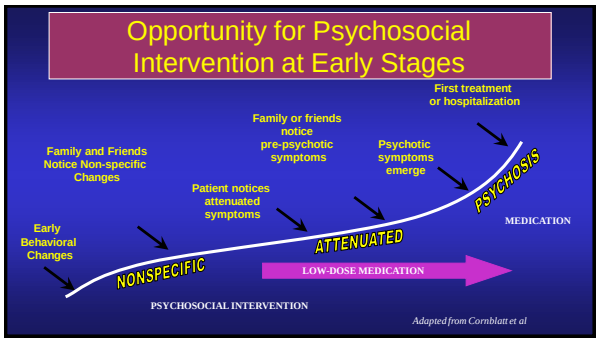
Opportunity for Psychosocial Intervention at Early Stages
First treatment or hospitalization
Family or friends notice pre-psychotic symptoms
Family and Friends Notice Non-specific Changes
Psychotic symptoms emerge
PSYCHOSIS
Patient notices attenuated symptoms
MEDICATION
Early Behavioral Changes
ATTENUATED
NONSPECIFIC
LOW-DOSE MEDICATION
PSYCHOSOCIAL INTERVENTION
Adapted from Cornblatt et al


Emerging Treatment Evidence
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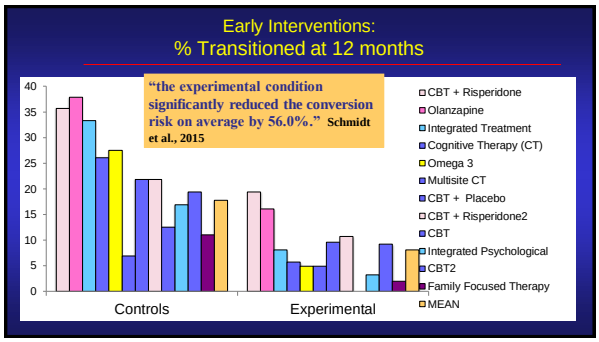
Early Interventions:
% Transitioned at 12 months
"the experimental condition significantly reduced the conversion risk on average by 56.0%." Schmidt et al., 2015
40
35
30
25
20
15
10
5
0
Controls
Experimental
CBT + Risperidone
Olanzapine
Integrated Treatment
Cognitive Therapy (CT)
Omega 3
Multisite CT
CBT + Placebo
CBT + Risperidone2
CBT
Integrated Psychological
CBT2
Family Focused Therapy
MEAN

What Treatments Work for Youth at Risk for Psychosis?

- Preliminary evidence for
  - Cognitive behavioral therapy (CBT)
  - Family focused treatment
  - Omega 3 fatty acids
  - Integrated specialized treatment
  - Low dose antipsychotic medications

Several important treatment targets: Conversion to psychosis, positive/ negative symptoms, social/role functioning, and cognition

Preti and Cella, 2010; Schmidt et al., 2015

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CEDAR Clinic: Center for Early Detection, Assessment, and Response to RIsk

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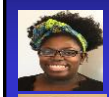
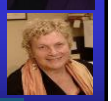
CEDAR Clinic Services



- Diagnostic Consultation
- Individual therapy
- Family treatment
- Psychiatry and health management
- School and work coaching
- Case management/ advocacy



Serving youth ages 14-30 at clinical high risk for psychosis

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Case Example: Jennifer

- Jennifer* - 20 year old female
- Referred by college counseling center after being put on academic suspension
- Chief complaint: "I've screwed up everything and I don't know who I can trust."

* Composite case example to protect confidentiality and illustrate treatment

Jennifer: Consultation/ Intake

- Clinical Interview and Structured interview for psychosis risk syndromes (SIPS)
- Stopped attending class and using computer/ phone due to concern she might* be monitored by professors and students
- Drinking several energy drinks each day
- Felt guilty/ hopeless/ cut off all contact with friends
- Previously high functioning (admitted to competitive university, large circle of friends)

* Maintained insight that this could be in her mind

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Role of Psychiatry in Treating Clinical High Risk

- Antipsychotic not generally used as first line treatment.
- Careful, individually-tailored approach based on diagnostic evaluation and case formulation
- Holistic, focus on five pillars (Sleep, Nutrition, Exercise, Social contact, Mindfulness)
- Emphasize nutrition/exercise to prevent metabolic side effects.
- Close collaboration with the clinical team

Therapy for Individuals at Clinical High Risk for Psychosis

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Therapy offered at CEDAR

- Psychoeducation
- Cognitive Behavior Therapy / Acceptance and Mindfulness Based Treatments
- Wellness/ relapse prevention planning
- Family psychoeducation and support
- School/ work coaching and support

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Psychoeducation

- Normalization/ de-catastrophizing
- Continuum
- Stress vulnerability

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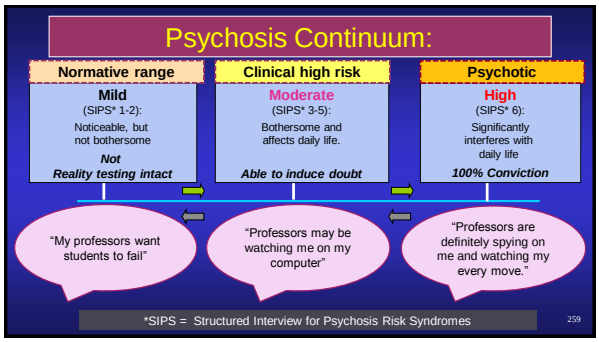
Psychosis Continuum:
Normative range
Clinical high risk
Psychotic
Mild
(SIPS* 1-2):
Noticeable, but not bothersome
Not
Reality testing intact
Moderate
(SIPS* 3-5):
Bothersome and affects daily life.
Able to induce doubt
High
(SIPS* 6):
Significantly interferes with daily life
100% Conviction
"My professors want students to fail"
"Professors may be watching me on my computer"
"Professors are definitely spying on me and watching my every move."
*SIPS = Structured Interview for Psychosis Risk Syndromes
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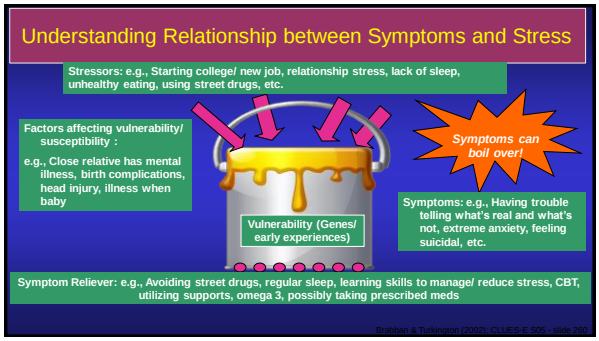
Understanding Relationship between Symptoms and Stress
Stressors: e.g., Starting college/ new job, relationship stress, lack of sleep, unhealthy eating, using street drugs, etc.
Factors affecting vulnerability/ susceptibility :
e.g., Close relative has mental illness, birth complications, head injury, illness when baby
Symptoms can boil over!
Vulnerability (Genes/ early experiences)
Symptoms: e.g., Having trouble telling what's real and what's not, extreme anxiety, feeling suicidal, etc.
Symptom Reliever: e.g., Avoiding street drugs, regular sleep, learning skills to manage/ reduce stress, CBT, utilizing supports, omega 3, possibly taking prescribed meds
Brabban & Turkington (2002). CLUES-E 505 - slide 260


Acceptance and Commitment Therapy and Cognitive Behavioral Therapy
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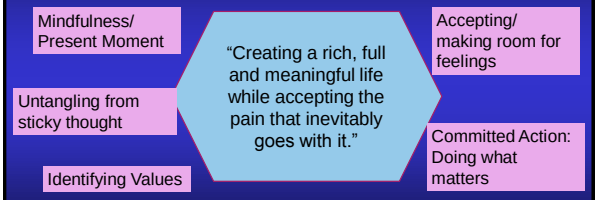
Acceptance and Commitment Therapy (ACT)



Harris (2009) *Act Made Simple,* New Harbinger Publications, Inc., p 7.

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Case Conceptualization

- Highlighting values and essential components of a meaningful life
  - Paying attention to what matters
  - Values exercises
  - Miracle question
- Evaluating barriers to flourishing
  - External (e.g., financial and social stressors)
  - Internal "sticky thoughts and feelings" (unhelpful rules and assumptions, unworkable actions, avoidance)
  - CHR Symptoms

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Treatment Planning: Helping Clients to…

- Act on values/ take steps towards goals
- Reduce impact of sticky thoughts, feelings and behaviors
- Increase hope and sense of resilience
- Specific skills may include:
  - Mindfulness
  - Challenging or stepping back from unhelpful rules/ assumptions/ beliefs
  - Making room for uncomfortable thoughts and feelings while doing what matters (exposure)

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Strategies for specific symptoms

- Paranoia/ unusual thought content
  - Focus on usefulness of behavioral response
  - Reducing safety behaviors
  - Consider alternate explanations
- Voices
  - Reduce power and control of voices
  - Identify triggers and vulnerability factors
- Disorganization and/or negative symptoms
  - Calendar and reminders
  - Scheduling pleasant and productive activities

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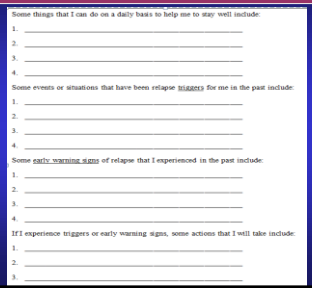
Wellness/Relapse Prevention Plan



Some things that I can do on a daily basis to help me to stay well include:

1. _____
2. _____
3. _____
4. _____

Some events or situations that have been relapse triggers for me in the past include:

1. _____
2. _____
3. _____
4. _____

Some early warning signs of relapse that I experienced in the past include:

1. _____
2. _____
3. _____
4. _____

If I experience triggers or early warning signs, some actions that I will take include:

1. _____
2. _____
3. _____

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Tools/ Resources

- RAISE NAVIGATE Manuals:
  - http://navigateconsultants.org/manuals/
  - Includes detailed guides for individual therapy, family therapy, etc.
- Treating Psychosis – videos and exercises
  - http://treatingpsychosis.com/resources/other-resources/
- CEDAR Clinic website links
  - www.cedarclinic.org → More information → For health professionals
  - http://cedarclinic.org/index.php?option=com_content&view=article&id=111&Itemid=111

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CEDAR Referral Contact

Worried about someone?

- Megan Graham, LMHC
  - 617-754-1223
  - mgraham1@bidmc.harvard.edu

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Live Skills Practice Workshop

MICHELLE L. WEST, PHD & CEDAR CLINIC STAFF
CEDAR CLINIC & RESEARCH PROGRAM
COMMONWEALTH RESEARCH CENTER OF BETH ISRAEL DEACONESS MEDICAL CENTER
MASSACHUSETTS MENTAL HEALTH CENTER

Exercise 1: Starting the Conversation

- "Jenny": 20 year-old female college student in her junior year, historically A-B grades. Long-standing history of depression, diagnosed at age 15, has done therapy for it. Presents to the counseling center, reporting that over the past 6 months she's noticed some changes. She described having worsened attention, organization, and grades (now C's). Noticing she's feeling like people are watching her and feels anxious they may want to harm her, but feels confused because she doesn't know why this would be. Has also noticed feeling more sensitive to sounds, and has been hearing whispers and noticing movement out of the corner of her eyes (but nothing is there when she checks). She feels worried that she is losing her mind.
- Exercise 1: Start the Conversation
  - Summarize her experience back to her
  - Normalize
  - Spectrum of symptoms
  - Vulnerability – stress bucket
  - Hope for change & treatment – therapy can help!

Exercise 2: Values Identification

- "Jenny": 20 year-old female college student in her junior year, historically A-B grades. Long-standing history of depression, diagnosed at age 15, has done therapy for it. Presents to the counseling center, reporting that over the past 6 months she's noticed some changes. She described having worsened attention, organization, and grades (now C's). Noticing she's feeling like people are watching her and feels anxious they may want to harm her, but feels confused because she doesn't know why this would be. Has also noticed feeling more sensitive to sounds, and has been hearing whispers and noticing movement out of the corner of her eyes (but nothing is there when she checks). She feels worried that she is losing her mind.
- Exercise 2: identify values, valued actions
  - What is important to the client? School, relationships, approach to life, etc.?
  - How is she doing in valued areas? What is interfering with valued actions?
  - Specific value-based behaviors she could increase?

Exercise 3: Targeting Paranoia

- "Jenny": 20 year-old female college student in her junior year, historically A-B grades. Long-standing history of depression, diagnosed at age 15, has done therapy for it. Presents to the counseling center, reporting that over the past 6 months she's noticed some changes. She described having worsened attention, organization, and grades (now C's). Noticing she's feeling like people are watching her and feels anxious they may want to harm her, but feels confused because she doesn't know why this would be. Has also noticed feeling more sensitive to sounds, and has been hearing whispers and noticing movement out of the corner of her eyes (but nothing is there when she checks). She feels worried that she is losing her mind.
- Exercise 3: CBT for paranoia
  - Identify a specific recent situation
  - Identify thoughts & certainty (e.g., "They want to hurt me" – 70%)
  - Identify & validate emotions, rate intensity (e.g., fear, paranoia, 7/10)
  - Identify behaviors related to these thoughts (e.g., avoidance?)
  - Teach cognitive restructuring, defusion strategies (e.g., evidence for/against, alternative thought)

Exercise 4: Targeting Hallucinations

- "Jenny": 20 year-old female college student in her junior year, historically A-B grades. Long-standing history of depression, diagnosed at age 15, has done therapy for it. Presents to the counseling center, reporting that over the past 6 months she's noticed some changes. She described having worsened attention, organization, and grades (now C's). Noticing she's feeling like people are watching her and feels anxious they may want to harm her, but feels confused because she doesn't know why this would be. Has also noticed feeling more sensitive to sounds, and has been hearing whispers and noticing movement out of the corner of her eyes (but nothing is there when she checks). She feels worried that she is losing her mind.
- Exercise 4: CBT for hallucinations
  - Identify a specific recent situation
  - Identify thoughts about the voices & certainty (e.g., "This means I'm going crazy" – 70%)
  - Identify & validate emotions, rate intensity (e.g., confusion, anxiety, 7/10)
  - Identify behaviors related to the hallucinations – discuss alternatives (e.g., grounding, distracting)
  - Teach cognitive restructuring of thoughts about voices (evidence for/against, alternative thought)

Closing Remarks

MATCHERI KESHAVAN, MD
DIRECTOR, COMMONWEALTH RESEARCH CENTER (CRC)
STANLEY COBB PROFESSOR OF PSYCHIATRY, HMS
VICE-CHAIR, DIVISION OF PUBLIC PSYCHIATRY, HMS