THE BeST GPS:
GOALS
PROGRAMS
SUPPORTS

ROADS TO RECOVERY CONFERENCE

10.21.24

BEST PRACTICES IN SCHIZOPHRENIA TREATMENT CENTER AT NORTHEAST OHIO MEDICAL UNIVERSITY

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BEST PRACTICES IN SCHIZOPHRENIA TREATMENT CENTER
A NEOMED CCoE

Northeast Ohio MEDICAL UNIVERSITY

OBJECTIVES

- Describe BeST Center-supported services available to individuals who experience psychosis and their family/natural supports
- Recognize eligibility criteria for each of the practice areas
- Describe how to access each of the practices provided by BeST Center community partners
- Define common facilitators and challenges to accessing services, and describe potential ways to overcome roadblocks to achieve recovery

Follow along with an individual and their loved ones as they journey through "BeST" practices within a system of care.

Join a family system as they enter into services, achieve successes, experience roadblocks, and build skills toward living their best lives.

As your guides, we will describe evidence-based and promising best practices encountered along the way.

BEST PRACTICES IN SCHIZOPHRENIA TREATMENT CENTER
A NEOMED CCoE

Northeast Ohio MEDICAL UNIVERSITY

WHO WE ARE:
BeST CENTER

- Best Practices in Schizophrenia Treatment (BeST) Center is a Coordinating Center of Excellence in the Department of Psychiatry at Northeast Ohio Medical University.
- Mission is to promote recovery and improve the lives of as many people with schizophrenia spectrum disorders and other serious mental health conditions – and their family/natural supports – as possible by accelerating the adoption of evidence-based and promising practices.
- Provide expert training, consultation, and technical assistance to community mental health agencies and hospital systems, including for first episode psychosis, since 2009.


WE WILL BE ADOPTING THE BEST PRACTICES IN OUR INDUSTRY, JUST LIKE EVERYONE ELSE.
BEST PRACTICES
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IF EVERYONE IS DOING IT, BEST PRACTICES IS THE SAME THING AS MEDIOCRE.
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STOP MAKING MEDIOCRITY SOUND BAD!
SORRY.

WHAT ARE EBPs?

...AND WHY SHOULD WE CARE?

EVIDENCE-BASED PRACTICES (EBPs)

- Clinical interventions
- Supported by evidence that they are effective
- Selected by providers and funders who want to deliver services to people that reflect the latest knowledge

EVIDENCE-BASED PRACTICES (EBPs)

- Outcomes superior to treatment (not just placebo or no treatment)
- Multiple randomized controlled trials
- Investigators in addition to original Principal Investigator
- Well-defined or manualized
- Replicable

EBPs: INTEGRATION OF:

WHY EBPs GET A BAD REP

Of course there's evidence behind this. Trust me!

- Touting a practice with some evidence as "Evidence-Based Practice"
- Doing EBP without ongoing evaluation of outcomes and/or fidelity to the model
- Adapting the EBP to the point it is no longer related to the original model
- Poor / no supervision

BeST CENTER'S EVIDENCE-BASED AND PROMISING PRACTICE AREAS

- clinical high risk for psychosis
- coordinated specialty care for first episode psychosis
- family education and support/family-based services
- cognitive behavioral therapy for psychosis
- cognitive remediation
- psychopharmacology
- integrated primary and mental health care

MINDSET: RECOVERY EMERGES FROM **HOPE**

- **Expect recovery:** It is more common than we think[1]
  - Roughly 25% remission after first episode
  - 15% late recovery
  - The majority have no problems with voices or delusions at 20-year follow up
  - 20% will experience chronic and debilitating symptoms
  - As many as 60-80% show recovery or "significantly improved" in longitudinal studies worldwide

LIKELIHOOD OF REMISSION IN SCHIZOPHRENIA

Study	Sample Size	Years Followed	Percent in Remission
Saravanan et al.	131	1	88%
Peuskens et al.	197	1	76%
Cassidy	141	2	56%
Wunderink et al.	125	2	52%
Potkin et al.	186	3	51%
Shennach-Wolff et al.	285	Not speficied	48%
Jager et al.	280	"until discharge"	45%
Boter et al.	498	1	40%
Henry et al.	723	7	37%
Li et al.	90	1 month after hospitalization	33%
Lambert et al.	529	1.5	33%
Novick et al.	6642	3	33%
Rossi et al.	347	1	32%

Remission = at least 6 months with minimal symptoms, or symptom-free

- Remission is an attainable goal for many
- These findings support an attitude of persistent optimism in psychosis care
- Optimizing medication use likely increases odds for remission

REFERENCE

- [1]American Psychological Association & Jansen, M. A. (2014). *Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders*. Washington, DC: American Psychological Association.

STARTING THE JOURNEY...

Destination: Recovery!

Entering the MH System

BEST PRACTICES IN SCHIZOPHRENIA TREATMENT CENTER
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Family-Based Services

ROLE OF FAMILY/NATURAL SUPPORTS

- "Family and natural supports"
  - Think broadly and inclusively
  - Integral to involve family system throughout treatment and recovery
- A systems approach to care
  - Expectation for engagement – no longer the exception
  - Key to think about individuals within a larger system
  - Consider: religion, values, beliefs, traditions, heritage, life experiences, cultural factors
- Mental illness and its impact on the family system
  - What impacts the individual impacts the system – and vice versa
  - Shift in roles

ROLE OF FAMILY/NATURAL SUPPORTS

- When knowledgeable and appropriately supportive families are engaged in treatment, outcomes are improved[1,2]:
  - Reductions in psychiatric relapses[3,4] and psychiatric hospital readmissions[4,5]
  - Improved family well-being[3,4,6], family relationships[7], social and occupational functioning[4,6], treatment adherence[4], overall quality of life[8], and work and role performance[9]
  - Decreased substance use[10], perceived family burden[7], burnout and exhaustion[11], economic impacts and costs of care[4,6,12] (including shorter length of inpatient hospitalization stays[13])
- Recommended by Schizophrenia Patient Outcomes Research Team (PORT)[14]

ENGAGING FAMILY/NATURAL SUPPORTS ACROSS PROGRAMS

- Enlisting family and natural supports as part of the treatment team
- Understanding the perspectives and experiences of individuals within the family system
- Reducing negative emotions and interactions within the FIRST participant's system
- Providing education and building skills
- Equipping the system to know how to handle difficult situations
- Improving outcomes for the FIRST participant and the individuals within the system

REFERENCES

- [8]Alshowkan, A., Curtis, J., & White, Y. (2012). Quality of life for people with schizophrenia: A literature review. The Arab Journal of Psychiatry, 23(2), 122-131.
- [11]Angermeyer, M., Bull, N., Bernert, S., Dietrich, S., & Kopf, A. (2006). Burnout of caregivers: A comparison between partners of psychiatric patients and nurses. Archives of Psychiatric Nursing, 20(4), 158-165.
- [9]Brekke, J., & Mathiesen, S. (1995). Effects of parental involvement on the functioning of noninstitutionalized adults with schizophrenia. Psychiatric Services, 46(11), 1149-1155. doi: 10.1176/ps.46.11.1149
- [10]Clark, R. (2001). Family support and substance use outcomes for persons with mental illness and substance use disorders. Schizophrenia Bulletin, 27(1), 93-101.
- [7]Cuijpers, P. (1999). The effects of family interventions on relatives' burden: A meta-analysis. Journal of Mental Health, 8(3), 275-285. doi: 10.1080/09638239917436

REFERENCES

- [14]Dixon, L., Dickerson, F., Bellack, A., Bennett, M., Dickinson, D., Goldberg, R., Lehman, A., Tenhula, W., Calmes, C., Pasillas, R., Peer, J., & Kreyenbuhl, J. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. Schizophrenia Bulletin, 36(1), 48-70. doi: 10.1093/schbul/sbp115
- [3]Dixon, L. B., & Lehman, A. F. (1995). Family Interventions for Schizophrenia. Schizophrenia Bulletin, 21(4), 631- 643. doi: 10.1093/schbul/21.4.631
- [6]Falloon, I. (1985). Family management of schizophrenia: A study of clinical, social, family, and economic benefits. John Hopkins University Press.
- [1]Glick, I., Stekoll, A., & Hays, S. (2011). The role of the family and improvement in treatment maintenance, adherence, and outcome for schizophrenia. Journal of Clinical Psychopharmacology, 31(1), 82-85.

REFERENCES

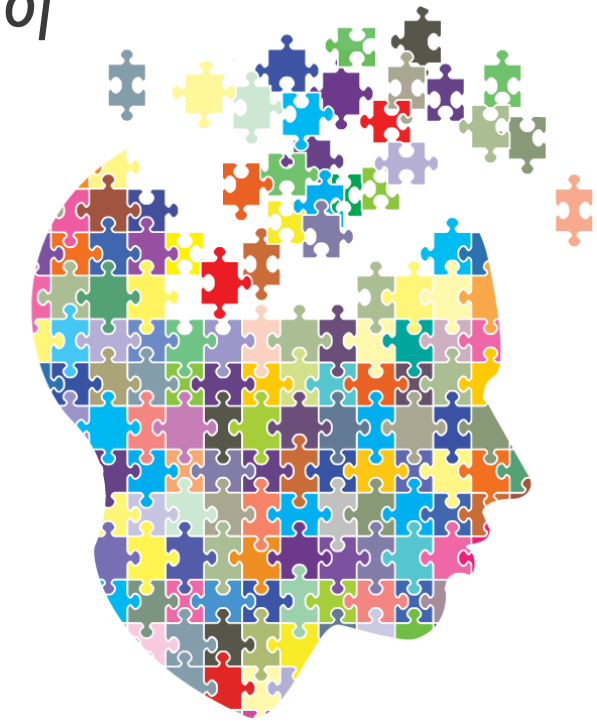
- [2]Jewell, T., McFarlane, W., Dixon, L., & Miklowitz, D. (2005). Evidence-Based family Services for Adults with Severe Mental Illness. In C.E. Stout & R.A. Hayes (Eds.), The evidence-based practice: Methods, models, and tools for mental health professionals (pp. 56-84). John Wiley & Sons, Inc.
- [12]Mangalore, R., & Knapp, M. (2007). Cost of schizophrenia in England. The Journal of Mental Health Policy and Economics, 10, 23–41.
- [4]McFarlane, W., Lukens, E., Link, B., Dushay, R., Deakins, S., Newmark, M., Dunne, E., Horen, B., & Toran, J. (1995). Multiple-family groups and psychoeducation in the treatment of schizophrenia. Archives of General Psychiatry, 52(8), 679-687. doi: 10.1001/archpsyc.1995.03950200069016
- [13]Pfammatter, M., Junghan, U., & Brenner, H. (2006). Efficacy of psychological therapy in schizophrenia: Conclusions from meta-analyses. Schizophrenia Bulletin, 32(1), S64-S80. doi: 10.1093.schbul/sbl030
- [5]Pitschel-Walz, G., Leucht, S., Bauml, J., Kissling, W., & Engel, R. (2001). The effect of family interventions on relapse and rehospitalization in schizophrenia: A meta-analysis. Schizophrenia Bulletin, 27(1), 73-92.

Cognitive Health

WHAT IS COGNITION?[1]

Mental processes relating to the input, storage, and use of information: to guide behavior and make sense of the world

- Attention
- Executive Functioning
- Flexibility
- Memory
- Planning
- Reaction Time
- Social Cognition



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DOMAINS OF COGNITION

Domain	Description
Processing Speed	The speed at which the brain controls the body to perform tasks
Attention	The ability to focus and sustain attention. Selectively attending to relevant information while ignoring distractions
Memory/Learning	Including episodic memory (relating to past or future events), semantic memory (knowledge of verbal memory/learning), and visuo-spatial memory/learning
Executive Functioning	The ability to monitor and regulate cognitive processes, directing and dividing attention, planning, working memory, mental flexibility, inhibition, task initiation and monitoring, multi-tasking, and decision-making

COGNITIVE HEALTH

- A healthy brain is one that can perform all the mental processes that are collectively known as cognition. This includes the ability to learn new things, pay attention, use intuition, judgment (decision-making and problem-solving), language, memory, planning, and goal setting.[3]

(GOOD) COGNITIVE HEALTH[4]

- Being able to focus for stretches of time
- Being able to recall someone's name
- Keeping your schedule up to date in your mind
- Cooking a new meal
- Thinking and speaking coherently
- Using your common sense

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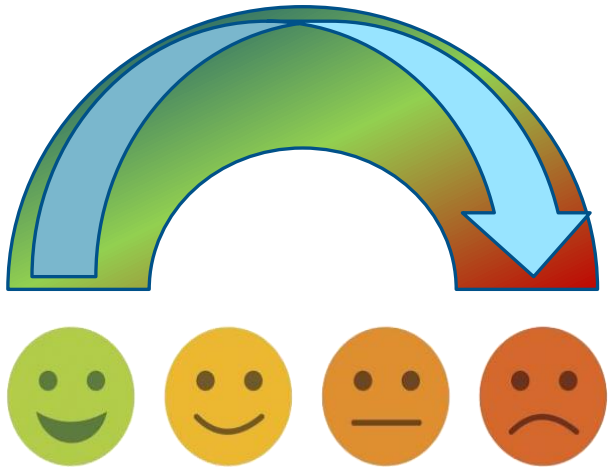
(POOR) COGNITIVE HEALTH[1]

- Difficulty with focus
- Not being able to recall names
- Missing appointments
- Not initiating
- Thinking and speaking is disorganized
- Using poor judgment



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COGNITIVE IMPAIRMENT: RISK FACTORS[4]

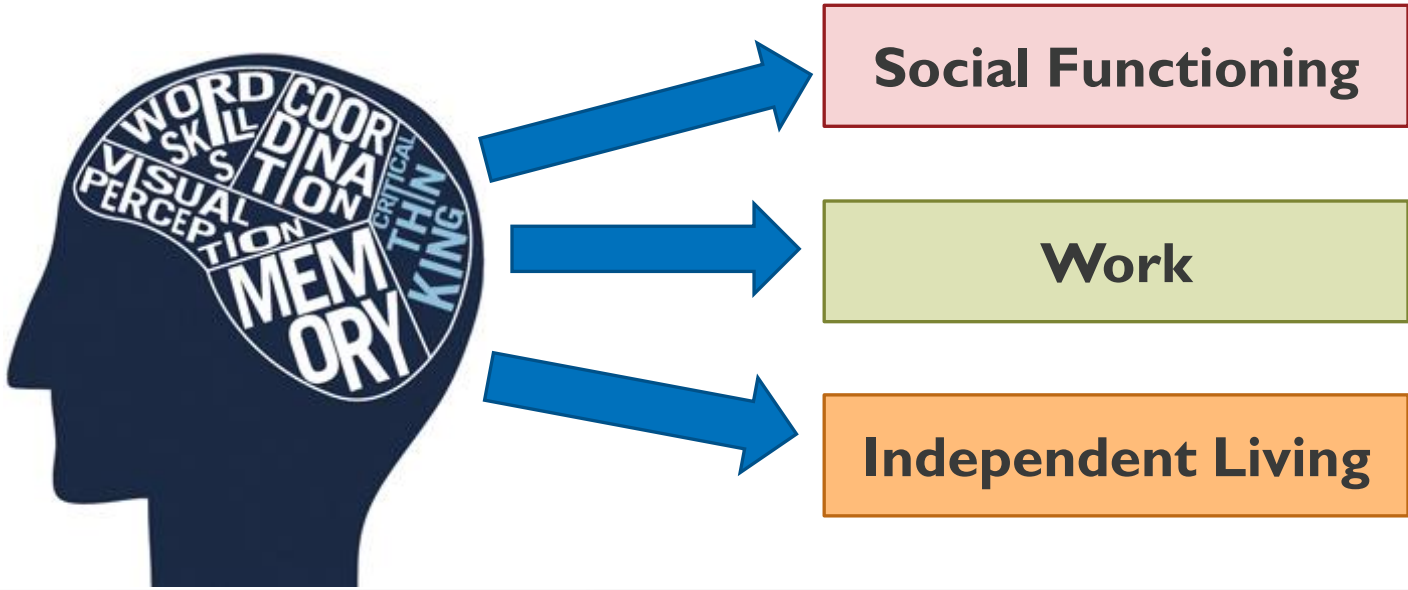
- Age
- Family history
- Education level
- Brain injury
- Exposure to pesticides/toxins
- Physical inactivity
- Certain medications

COGNITIVE IMPAIRMENT: CONTRIBUTING FACTORS[4]

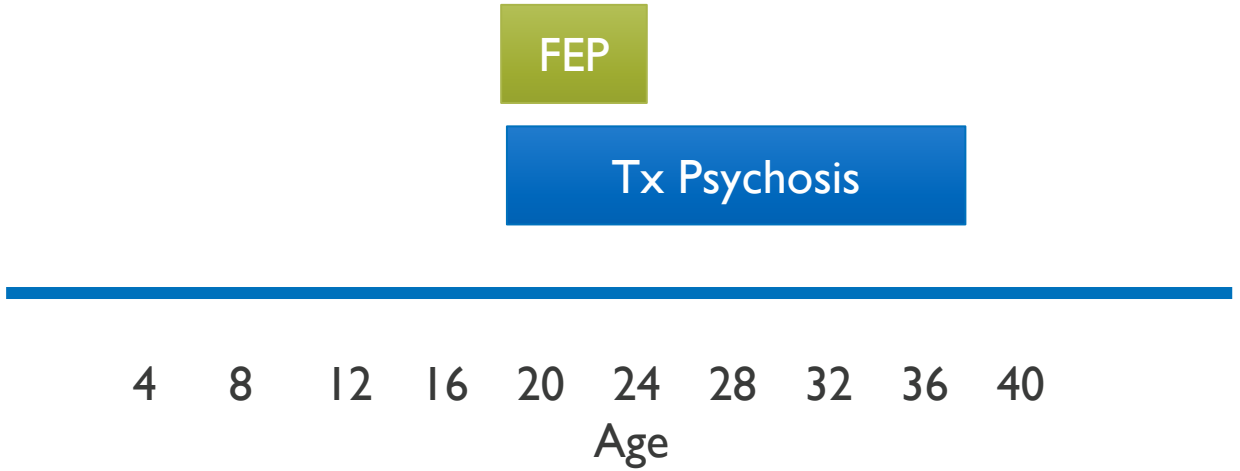
- Heart disease, Stroke, Diabetes, Parkinson's Disease
- Substance use
- Mental illness
  - Schizophrenia
  - Major Depressive Disorder
  - Bipolar Disorder
  - Anxiety disorders
- Diet, nutrition
- Hydration
- Sleep
- Lack of physical activity
- Lack of mental stimulation

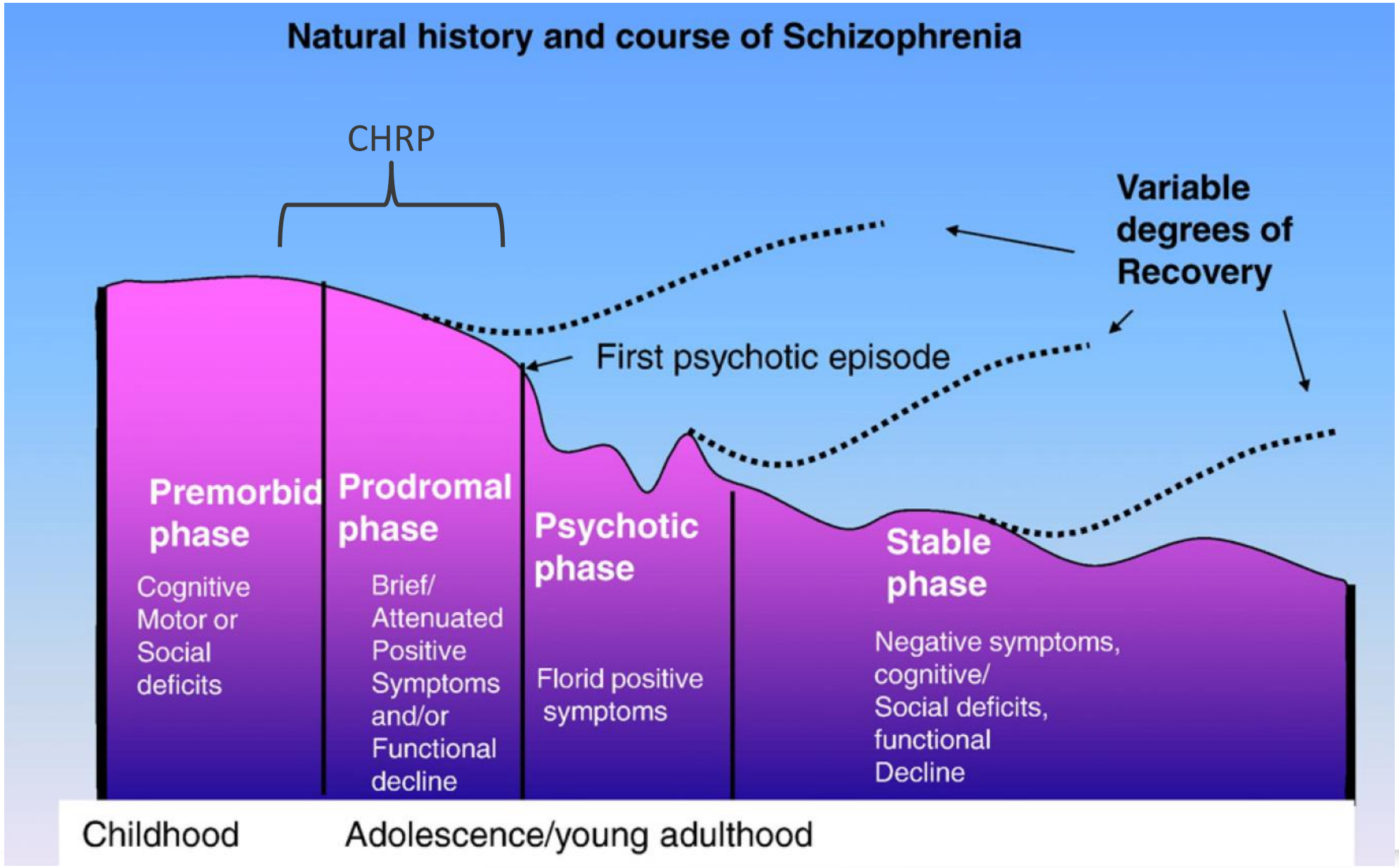
COGNITIVE DIFFICULTIES IN PSYCHOSIS

- Apparent before onset of psychosis
- Span multiple domains
- Persist into remission
- Predict functioning



DURATION OF UNTREATED PSYCHOSIS[5]




Natural history and course of Schizophrenia
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Variable degrees of Recovery
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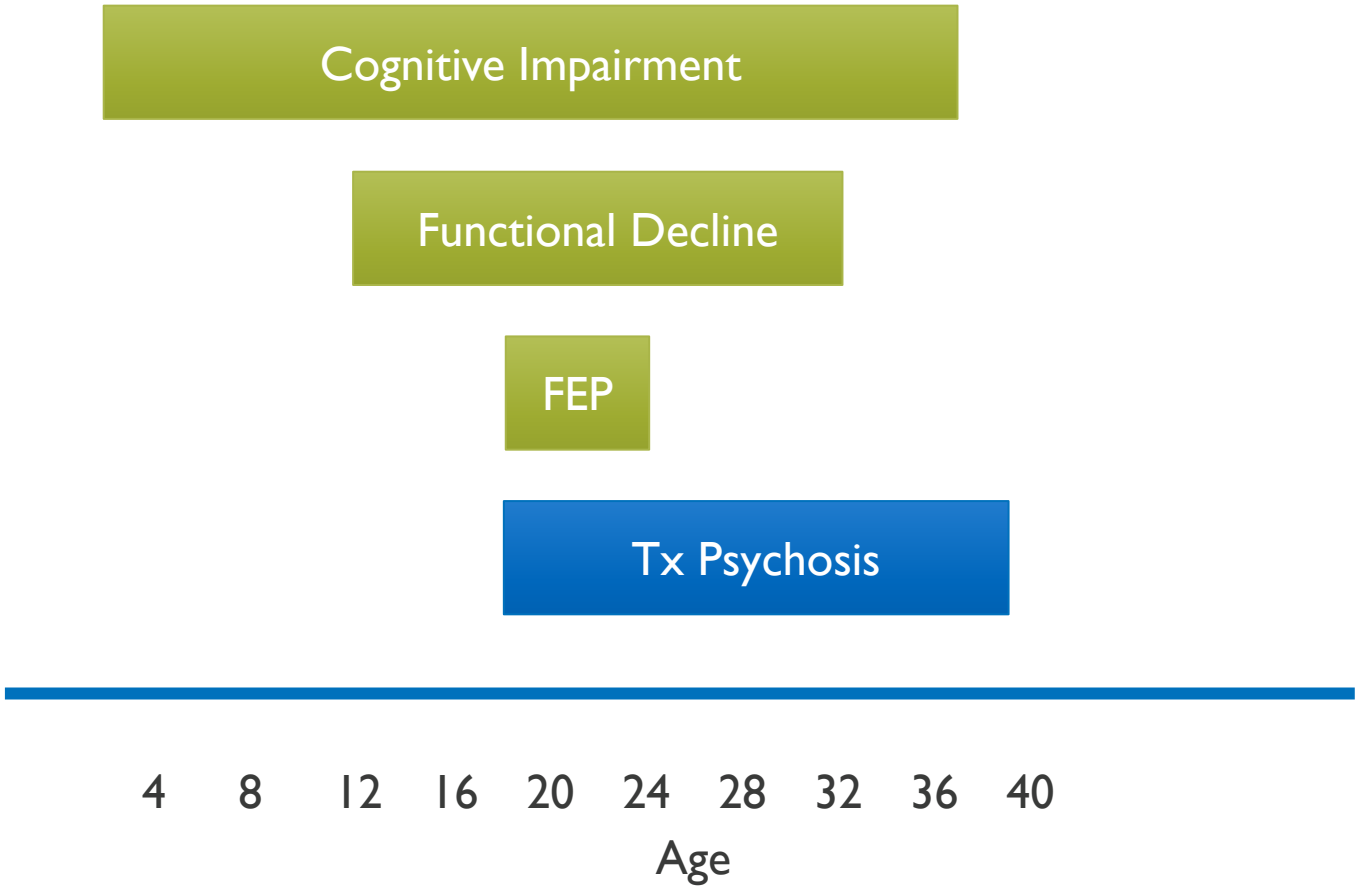
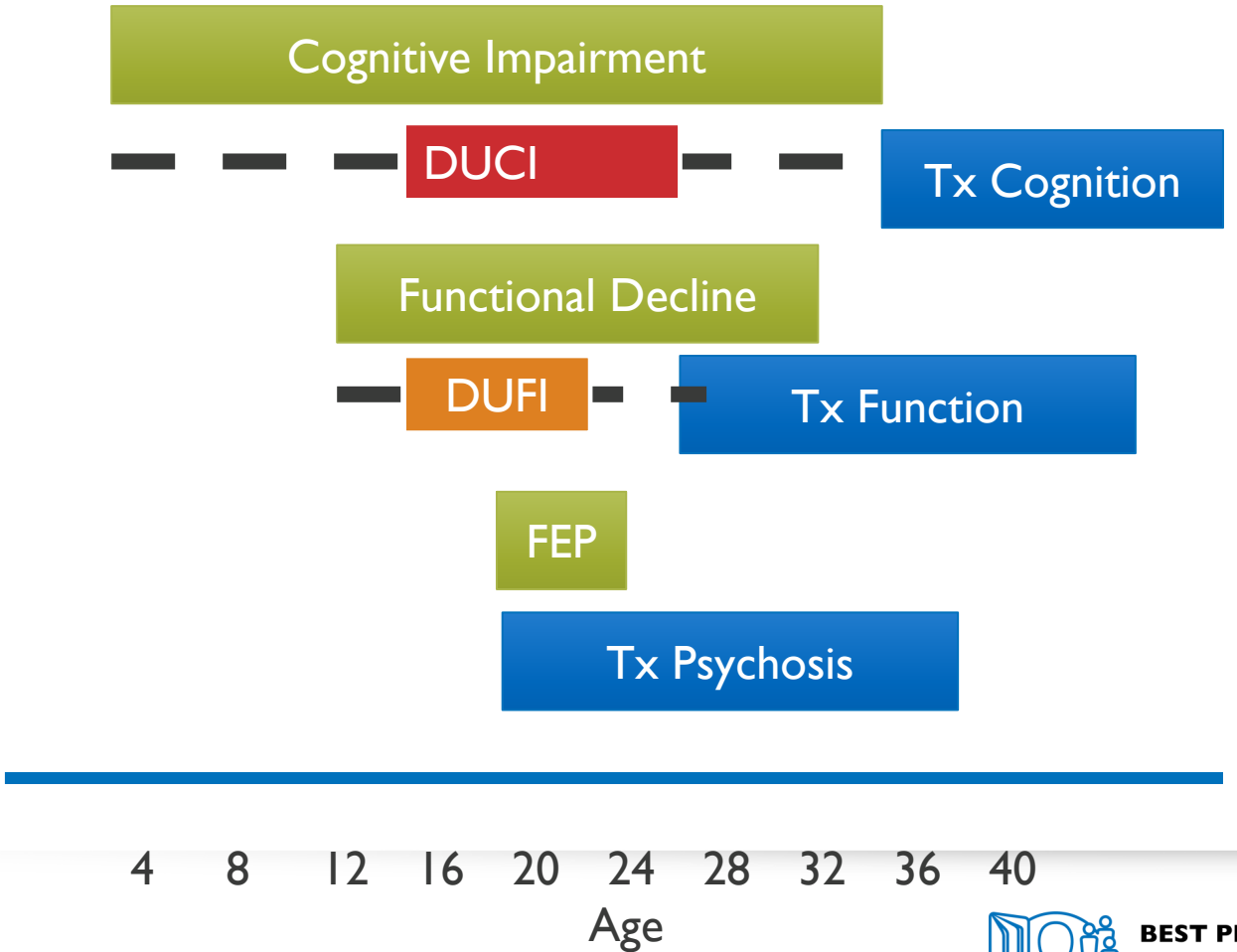
Cognitive Motor or Social deficits
Prodromal phase
Brief/ Attenuated Positive Symptoms and/or Functional decline
Psychotic phase
Florid positive symptoms
Stable phase
Negative symptoms, cognitive/ Social deficits, functional Decline
Childhood
Adolescence/young adulthood

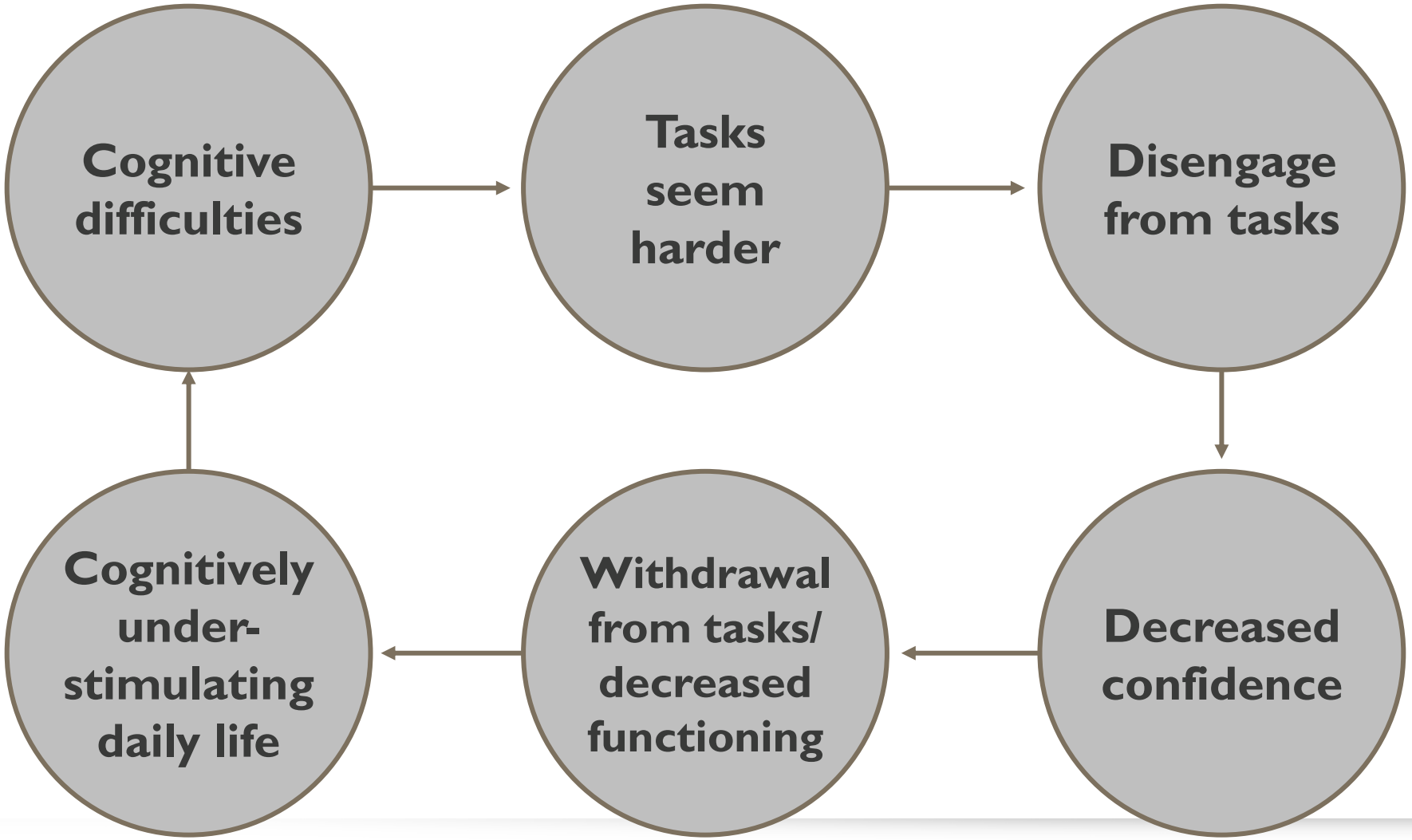
COGNITIVE & FUNCTIONAL DECLINE PRECEDE PSYCHOSIS[5]



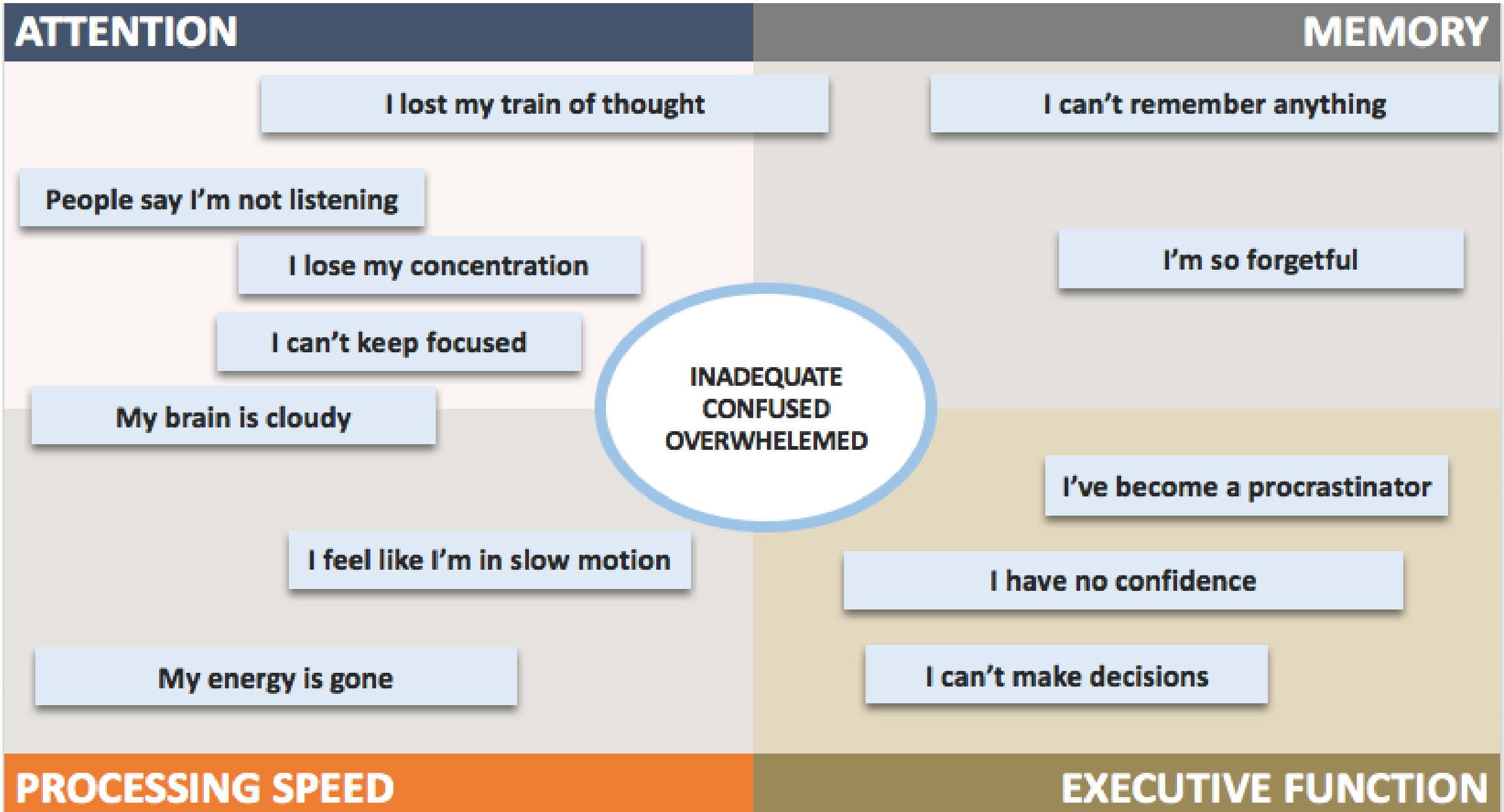
IS DUP AS CRITICAL AS:[5]
DUCI (Duration Of Untxed Cognitive Impairment)?
DUFI (Duration Of Untxed Functional Impairment)?



COGNITION AND FUNCTIONING: A FEEDBACK MODEL[5]



DON'T MISTAKE *COGNITIVE ISSUES* FOR *BEHAVIORAL PROBLEMS*[5]



(COGNITIVE) HEALTH APPROACHES

- Exercise[8]
- Healthy diet[9]
- Sleep[9]
- Mental stimulation[3]
- Social contacts[1,4,7]
- Manage stress

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COGNITIVE HEALTH IS THE GOAL[10]

- Recognizing strengths and challenges
- Shared decision-making in identifying approach(s)
- Whole person approach

REFERENCES

- [5]Bowie, C.R. (August 10, 2020). *Action Based Cognitive Remediation (ABCR)* [Webinar].
- [7]Cacioppo, S., Grippo, A.J., London, S., Goossens, L., Cacioppo, J.T. (2015). Loneliness: clinical import and interventions. Perspectives on Psychological Science. 10(2), 238-49.
- [8]Hallgren, M., Skott, M., Ekblom, Ö., Firth, J., Schembri, A., & Forsell, Y. (2018). Exercise effects on cognitive functioning in young adults with first-episode psychosis: Fitforlife. Psychological Medicine, 49(3), 431–439. https://doi.org/10.1017/s0033291718001022.

REFERENCES

- [9]Harvard Health Publishing. (2021, January 2). Protecting against cognitive decline. Retrieved March 18, 2022, from https://www.health.harvard.edu/mind-and-mood/protecting-against-cognitive-decline.
- [1]Medalia, A. (2002). Dealing with Cognitive Dysfunction associated with psychiatric disabilities: A Handbook for Families. New York State Office of Mental Health. Retrieved March 18, 2022, from https://omh.ny.gov/omhweb/cogdys_manual/cogdyshndbk.pdf.
- [3]National Institute on Aging (NIA). (2020). Cognitive health and older adults. National Institute on Aging. Retrieved March 18, 2022, from https://www.nia.nih.gov/health/cognitive-health-and-older-adults

REFERENCES

- [6]Tandon, R., Nasrallah, H. A., & Keshavan, M. S. (2009). Schizophrenia, "just the facts" 4. Clinical features and conceptualization. Schizophrenia research, 110(1-3), 1–23. https://doi.org/10.1016/j.schres.2009.03.005
- [10]U.S. Department of Health and Human Services. (2020). Cognitive health and older adults. National Institute on Aging. Retrieved March 22, 2022, from https://www.nia.nih.gov/health/cognitive-health-and-older-adults
- [4]U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2011). Cognitive impairment: A call for action, now! U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved March 18, 2022, from https://www.cdc.gov/aging/pdf/cognitive_impairment/cogimp_poilicy_final.pdf.

STARTING THE JOURNEY

Early indicators

WHAT MIGHT BE EXPERIENCED OR OBSERVED BEFORE ENTERING THE MENTAL HEALTH SYSTEM[1,2]

- Increased difficulty with work or school
- Difficulty concentrating or thinking clearly
- Odd thinking or behavior
- Feeling like something is just not right
- Feeling afraid with no apparent reason
- Hearing things or voices that no one else can hear

WHAT MIGHT BE EXPERIENCED OR OBSERVED BEFORE ENTERING THE MENTAL HEALTH SYSTEM[1,2]

- Withdrawal from usual interests, hobbies, friends, and family
- Poor personal hygiene
- Baseline functioning begins to fail/deteriorate
- Having trouble putting words and sentences together clearly – disorganized thoughts; confusion
- Emotional outbursts for no apparent reason
- Change in sleep habits

REFERENCES

- [1]Van der Gaag, M., Nieman, D., & van den Berg, D. (2013). *CBT for Those at Risk of a First Episode Psychosis. Evidence-based psychotherapy for people with an "At Risk Mental State"*. London: Routledge. doi: 10.4324/9780203503478
- [2]Tandon, R., Nasrallah, H. A., & Keshavan, M. S. (2009). Schizophrenia, "just the facts" 4. Clinical features and conceptualization. Schizophrenia research, 110(1-3), 1–23. https://doi.org/10.1016/j.schres.2009.03.005

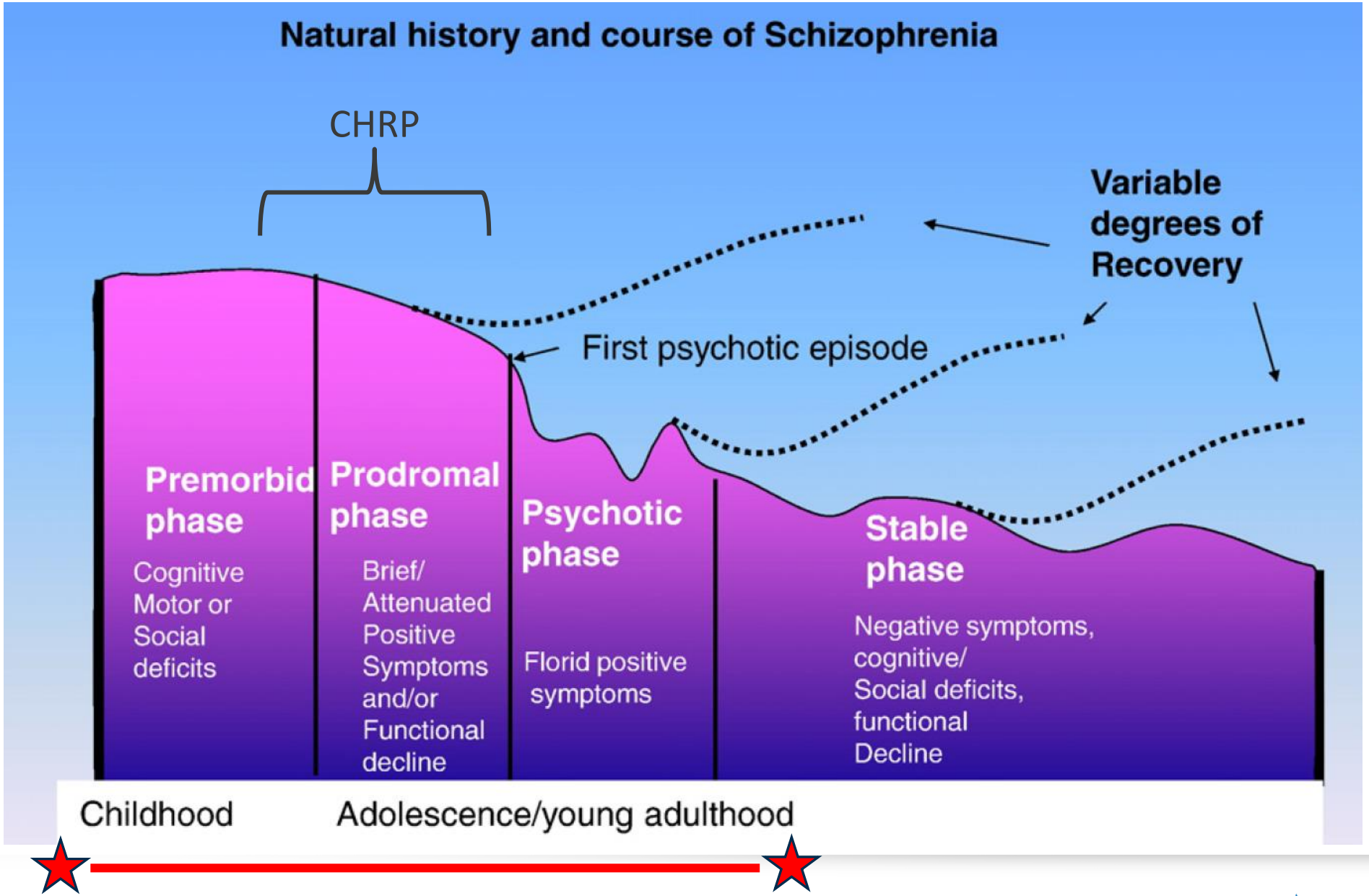
Clinical High Risk for Psychosis

CLINICAL HIGH RISK FOR PSYCHOSIS (CHRP)

- Mid to late 1990s: Concept of clinical high risk for psychosis originated with research from Australia and Europe, later expanded to United States
- Goal of prevention / delaying transition to psychosis
- "Prepsychotic" phase[1]
  - Present with potentially prodromal symptoms[1]
- Typically experience some kind of distress, so often seek help[2]

CHRP

- Early warning signs are non-specific:[3]
  - Feel as though something is "off" / "not quite right"
  - Confusion
  - Trouble communicating clearly
  - Fearful without cause
  - Lessening interest in activities, people, self-care
  - Worsening in functioning (work, school, self-care)
  - Observations of others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Adolescence/young adulthood

CRITERIA AND COMORBIDITIES

- CHRP syndromes:
  - Attenuated Positive Symptom Psychosis Risk Syndrome (APS)
  - Brief Intermittent Psychotic Symptom Psychosis-Risk Syndrome (BIPS)
  - Genetic Risk and Deterioration Psychosis Risk Syndrome (GRD)
- At baseline, more than 70% of CHR population had at least 1 diagnosable disorder[4]
  - Most common comorbid diagnoses: **anxiety and depressive disorders**[7] and social phobia[4] (as cited in 12)
  - Many CHRP individuals have 2-3 comorbid diagnoses[7]

TREATMENT

- Prevention is powerful
- Targeted psychosocial interventions reduce frequency of conversion to psychosis (or delay the onset of symptoms, with better outcomes)[9]
- International reviews emphasize:[10,11,11a]
  - Tailored therapy (titrated to need)
  - Assessment
  - Case/care management
  - Close involvement of family and natural supports

CHRP OUTCOMES

- To predict transition to psychosis, look for presence of a combination of specific subclinical symptoms and risk factors[9]
- Current conversion to psychosis rates:
  - At one year: 15%[6]
  - At two years: 20%[6]
  - At four years: 25-30%[6]

CHR-P OUTCOMES AND LONG-TERM FOLLOW-UP

- Trend is that transition to psychosis plateaus after 3 years, 25-30%[6], but there is evidence of late transition after 4 years[13]
- In one long term study, roughly half of CHRp participants reach remission of CHRp symptoms, however: [13]
  - Many present with other diagnoses
  - Many present with poor functional outcomes
  - In this sample, 28% achieve full recovery (clinically and functionally)

CHR-P OUTCOMES AND LONG-TERM FOLLOW-UP

- Take home message: Importance of continued monitoring and service beyond initial 2-3 years

REFERENCES

- [7]Addington, J., Piskulic, D., Liu, L., Lockwood, J., Cadenhead, K., Cannon, T., Cornblatt, B., McGlashan, T., Perkins, D., Seidman, L., Tsuang, M., Walker, E., Bearden, C., Mathalon, D., & Woods, S. (2017). Comorbid diagnoses for youth at clinical high risk of psychosis. *Schizophrenia Research, 190*, 90-95. doi: 10.1016/j.schres.2017.03.043
- [13]Beck, K., Studerusa, Andreoua, Egloffb, Leanzaa, Simond, Borgwardtf, Riecher-Rösslerg (2019). Clinical and functional ultra-long-term outcome of patients with a clinical high risk (CHR) for psychosis. *European Psychiatry 62,* 30–37.
- [12]Chan, V. (2017). Schizophrenia and psychosis: Diagnosis, current research trends, and model treatment approaches with implications for transitional age youth. *Child and Adolescent Psychiatric Clinics of North America, 26*(2), 341-366. doi: 10.1016/j.chc.2016.12.014

REFERENCES

- [4]Menefee, E. (March 18, 2021). Early psychosis syndromes: Building programs for the future. Presented at the Research Seminar in Child and Adolescent Psychiatry. Denmark.
- [10]Estradé, A., Spencer T.J., De Micheli, A, Murguia-Asensio, S., Provenzani, U., McGuire, P., & Fusar-Poli, P. (2023). Mapping the implementation and challenges of clinical services for psychosis prevention in England. *Front. Psychiatry, 13*:945505. doi: 10.3389/fpsyt.2022.945505
- [1]Fusar-Poli et al. (2013). The psychosis high-risk state: A comprehensive state-of-the-art review. *JAMA Psychiatry, 70*(1), 107-120. doi: 10.1001/jamapsychiatry
- [6]Lundin, N. B., Blouin, A., Cowan, H., Moe, A., Wastler, H., & Breitborde, N. (2024). Identification of psychosis risk and diagnosis of first-episode psychosis: Advice for clinicians. *Psychology Research and Behavior Management, 17*, 1365-1383. doi: 10.2147/PRBM.S423865

REFERENCES

- [2]Parsons (Path), E. (September 9, 2022). Update on psychosis risk syndrome research: Recent findings and major initiatives. Presented at the 2022 Community Education Day for Psychosis (Stanford INSPIRE Clinic – UCSF Path Program). Virtual. https://med.stanford.edu/psychiatry/patient_care/inspire/2022communityday.html
- [11]Salazar de Pablo, G., Estradé, A., Cutroni, M., Andlauer, O., & Fusar-Poli, P. (2021). Establishing a clinical service to prevent psychosis: What, how and when? Systematic review. *Translational Psychiatry 11*(1), 43. doi: 10.1038/s41398-020-01165-x
- [11a]Salazar de Pablo, G., Radua, J., Pereira, J., Bonoldi, I., Arienti, V., Besana, F., Soardo, L., Cabras, A., Fortea, L., Catalan, A., Vaquerizo-Serrano, J., Coronelli, F., Kaur, S., Da Silva, J., Shin, J., Solmi, M., Brondino, N., Politi, P., McGuire, P., & Fusar-Poli, P. (2021). Probability of transition to psychosis in individuals at clinical high risk: An updated meta-analysis. *JAMA Psychiatry, 78*, 970-978. doi: 10.1001/jamapsychiatry.2021.0830

REFERENCES

- [3]Schiffman, J. (August 21, 2020). Clinical high risk for psychosis: Screening, assessment, and treatment. Presented at the 2020 Southwest First Episode Psychosis Conference. Virtual. https://mhttcnetwork.org/products_and_resources/clinical-high-risk-for-psychosis-screening-assessment-and-treatment/
- [5]Tandon, R., Nasrallah, H. A., & Keshavan, M. S. (2009). Schizophrenia, "just the facts" 4. Clinical features and conceptualization. *Schizophrenia Research, 110*(1-3), 1–23. doi: 10.1016/j.schres.2009.03.005
- [9]Van der Gaag, M., Nieman, D., & van den Berg, D. (2013). *CBT for Those at Risk of a First Episode Psychosis. Evidence-based psychotherapy for people with an "At Risk Mental State"*. London: Routledge. doi: 10.4324/9780203503478

First Episode Psychosis

BEST PRACTICES
IN SCHIZOPHRENIA
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THE TRANSITION FROM RISK STATES TO FIRST EPISODE

- **CHRP:**
  - Recognizes changes are occurring[4]
  - Can appreciate altered perceptions are not real[4]
  - Maintains some insight into psychotic-like experiences[4]
  - Some ambivalence/questioning about reality of experiences – can offer or induce doubt[2]
  - Experiences are bothersome and/or affect daily life[2]
- **FIRST Episode:**
  - Clear symptoms of psychosis develop
  - 100% conviction about unusual experiences[2]
    - Believes experiences to be indisputably true
  - Symptoms significantly interfere with daily life[2]

COMMON CHALLENGES ASSOCIATED WITH EARLY PSYCHOSIS FOR STUDENTS

Symptoms	Academic, Interpersonal, and/or Environmental Challenges
Disorganized thinking	Difficulty following lectures, tracking conversations, completing reading assignments
Perceptual experiences (e.g., hearing voices, seeing images)	Distraction while trying to concentrate during tests, exams, and presentations
Suspicious or unusual thoughts	Anxiety or fear of others; challenges or withdrawal from relationships and friends, classmates, family, and instructors
Cognitive problems	Trouble with memory, attention, or planning
Depression and/or negative thoughts	Low motivation for self-care, exercise, low self-esteem, demoralization, internalized stigma, fatigue or trouble sleeping, feeling overwhelmed or low stress tolerance, suicide, or self-harm thoughts

FIRST

FIRST Coordinated Specialty Care for First Episode Psychosis

A comprehensive, team-based treatment program aimed at improving the mental health and quality of life for individuals who have experienced a first episode of psychosis

- Promotes early identification
- Provides best treatment practices as soon as possible
- Coordinated specialty care shows positive outcomes[1]

A partnership of:

- Community mental health agencies
- Local mental health and recovery boards
- Ohio Department of Mental Health and Addiction Services
- BeST Center

FIRST CRITERIA

FIRST is appropriate for individuals:

- Diagnosed with schizophrenia, schizoaffective, schizophreniform, or other specified/unspecified schizophrenia-spectrum disorder; bipolar disorder with psychotic features; or other psychotic disorder
- Between 15-40 years of age
- Experiencing no more than 18 months of psychotic symptoms, whether treated or untreated
- Willing to consent to participate in at least two of the five treatment modalities

FIRST GOALS

- Reduce the symptoms of psychotic illnesses
- Improve individual and family functioning
- Reduce the chance of relapse of psychosis
- Promote recovery and improve the long-term course of the illness
- Decrease the overall costs of treatment

FIRST PROGRAM

- FIRST treatment is a manualized, team-based approach
- The duration for FIRST treatment is typically three to five years, depending on the individual's needs and preferences
- There are 5 service areas to select from
  - Some teams also have RN's and Peer Recovery Supporters

FIRST SERVICES

- **Individual Resiliency Training**
  - Helps individuals gain insight into their illness and develop tools for coping
  - Focuses on strengthening problem-solving abilities

FIRST SERVICES

- **Case Management**
  - Assists with coordination of medical and mental health care
  - Educates individuals on community resources and assists with integration into the community
  - Provides illness education, skills training, and motivational enhancement
  - Provides crisis management as needed

FIRST SERVICES

- **Psychiatric Care**
  - Focuses on providing medications and interventions
  - Emphasis on shared decision-making

FIRST SERVICES

- **Supported Employment / Education**
  - Focuses on rapid return to or initiation of employment or education
  - Takes place at community sites
  - Is driven by participants' needs and preferences

FIRST SERVICES

- **Family Education and Support**
- **Family Psychoeducation**
  - Not therapy for families; focus is on skill-building, education, and support
  - Evidence-based, longer-term intervention
  - Involves the family system as part of the treatment team – individual participant in FIRST and identified family/natural supports
  - Allows family system to ask questions and work through concerns before a situation becomes a crisis

FIRST SERVICES

- **Family Psychoeducation**
  - Work with a trained Clinician to learn about and practice skills in:
    - Personal and family system goal-setting
    - Defining Recovery
    - Resiliency
    - Communication
    - Problem-solving
    - Psychosis and medication information
    - Coping
    - Substance use
    - Collaborating with providers
    - Relapse prevention

REFERENCES

- [1]Kane, J. et al. (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes from the NIMH RAISE Early Treatment Program. *AmJ Psychiatry, I 73*, 362–372; doi: 10.1176/appi.ajp.2015.15050632
- [4]Menefee, E. (March 18, 2021). Early psychosis syndromes: Building programs for the future. Presented at the Research Seminar in Child and Adolescent Psychiatry. Denmark.

REFERENCES

- [2]Parsons (Path), E. (September 9, 2022). Update on psychosis risk syndrome research: Recent findings and major initiatives. Presented at the 2022 Community Education Day for Psychosis (Stanford INSPIRE Clinic – UCSF Path Program). Virtual. https://med.stanford.edu/psychiatry/patient_care/inspire/2022communityday.html
- [3]National Association of State Mental Health Program Directors. (2016). Toolkits to Support the Full Inclusion of Students with Early Psychosis in Higher Education. Retrieved from https://www.nasmhpd.org/sites/default/files/Toolkit-Back_to_School_Support_for_Full_Inclusion_of_Students_with_Early_Psychosis_in_Higher_Education.pdf

Pharmacotherapy

PHARMACOTHERAPY

MEDICATIONS AS TOOLS FOR RECOVERY

GOALS OF PHARMACOTHERAPY

- Remission of symptoms
- Restoration of function
- Fullest possible level of recovery

OPTIMIZING MEDICATION

- Choosing goal of remission
- Accurate diagnosis
- Rational medication selection
- Minimizing side effects
- Systematic monitoring of therapeutic response
- Evidence-based and logic-based changes in cases of inadequate therapeutic response

ACCURATE DIAGNOSIS

- Psychosis is like fever
  - Relatively easy to recognize
  - Nonspecific symptom; can arise from many different underlying conditions
- Medications only work if the things that the medication affects are the things that are producing the symptoms
  - Antibiotics can reduce a fever caused by bacterial infection
  - Fever caused by viral infection is "treatment-resistant" to antibiotics

The first step in antipsychotic pharmacotherapy is to clarify the diagnosis

MANY CAUSES OF PSYCHOSIS

- Pharmacological psychosis
  - Over 100 different medications or recreational drugs can produce psychosis as a side effect or during withdrawal
- Medical psychosis
  - At least 50 different medical diseases can have psychosis as a symptom
  - Reports of between 5-7% of psychosis with an underlying medical cause[1,2]
- Psychiatric psychosis
  - At least 6 different psychiatric syndromes are associated with psychosis as a symptom

MONITORING RESPONSE

- Remission of symptoms is the goal of treatment
- Side effects should be avoided or minimized to acceptable level
- Medications should produce desired results within a defined time frame (6 to 16 weeks)
- All individuals, family/natural supports, and providers/treatment teams are able to track interventions and outcomes!

RESPONSE TRACKING TEMPLATE EXAMPLE

Summary of outpatient clinic notes

Date	Clonazepam	Venlafaxine	Abilify	Seroquel	Trazodone	Buspirone	Chart note observations
4/23/19	1	150	5		50		Doing fairly well. Anxiety fairly well-managed.
9/1/19	1	150	5 (⬇️ to 2.5)		50		No mood complaints. % tremors in her right arm. Admits trouble writing at times. ⬇️ Decrease Ablify to 2.5 (from 5)
3/2/20	1 ⬆️ 1.5 mg/day	150	0		50		Experiencing some increased anxiety. Worried about glaucoma and (?) Parkinson's. Neurologist told her to stop Abilify, which she did. She is staying focused on issues and health which she is not able to control. "Encouraged to learn different techniques how to cope with her anxiety symptoms" ⬆️ Increase clonazepam to 0.5 mg up to TID
6/16/20	1.5	150 ⬆️ 187 mg/d			50		P 69; BP 133/86; 5' 3", 112 lbs, BMI 19.8 Slightly better, but Very nervous/shaky in the mornings. Somatically preoccupied High degree of anxiety, excessive amount of worries, has trouble relaxing.
8/4/20	1.5	187			50	⬆️ 30	Feeling somewhat better. Feels that extra venlafaxine has helped. Anxious and overwhelmed in the morning until she starts taking her medications. ⬆️ Buspirone added.
8/10/20	1.5	187				30	Calls with report of hearing voices

RESPONDING TO INADEQUATE RESPONSE

- If results are inadequate:
  - Re-assess diagnosis
  - Search for sources of interference (unexpected side effect from some other drug, excessive stress, etc.)
  - Consider change of medication
  - Clozapine is often recommended when there is an inadequate response to two antipsychotic medications[3,4]

BEST CENTER PHARMACOTHERAPY SERVICES

- Training for prescribing clinicians
- Weekly online education, telementoring, and case consultation for prescribing clinicians
- On-demand consultation with clinicians from FIRST teams
- Clinician assistance with medication selection, side effect management, inadequate treatment response
- Clozapine assistance for prescribing clinicians
- Lectures to interested groups about psychosis, schizophrenia, or medications

REFERENCES

- [4]Agid, O. et al. (2011) An algorithm-based approach to first-episode schizophrenia: response rates over 3 prospective antipsychotic trials with a retrospective data analysis. J. Clin. Psychiatry 72, 1439–1444
- [1]Johnstone, E. C., Macmillan, J. F. & Crow, T. J. The occurrence of organic disease of possible or probable aetiological significance in a population of 268 cases of first episode schizophrenia. Psychol. Med. 17, 371–379 (1987).
- [2]Johnstone, E. C., Crow, T. J., Johnson, A. L. & MacMillan, J. F. The Northwick Park Study of first episodes of schizophrenia. I. Presentation of the illness and problems relating to admission. Br. J. Psychiatry 148, 115–120 (1986).
- [3]Lieberman, J. A. et al (1994). Clinical effects of clozapine in chronic schizophrenia: response to treatment and predictors of outcome. Am. J. Psychiatry 151, 1744–1752

ROADBLOCK...RECALCULATING!

Family-Based Services: LINC

LOVED ONES INVOLVED IN A NETWORK OF CARE

- Unique and innovative short-term family psychoeducation and engagement program
- *Not* therapy
  - It is psychoeducation and skill-building using a manualized approach to care
- Offers supportive education and assistance with coordinating care to those diagnosed with **schizophrenia spectrum, bipolar I or II, or major depressive disorders** and their identified family/natural supports

LOVED ONES INVOLVED IN A NETWORK OF CARE

- Provides individuals and their family systems with practical, immediate help and support when they need it most...during:
  - Crisis/hospitalization
  - Critical transition between inpatient and outpatient treatment
  - Intensive Outpatient Services (IOP)
- Individuals and family/natural supports are introduced to the program during a psychiatric hospitalization or participation in a psychiatric IOP at **MetroHealth**
  - Program continues in the outpatient setting with a LINC-trained clinician at MetroHealth

LOVED ONES INVOLVED IN A NETWORK OF CARE

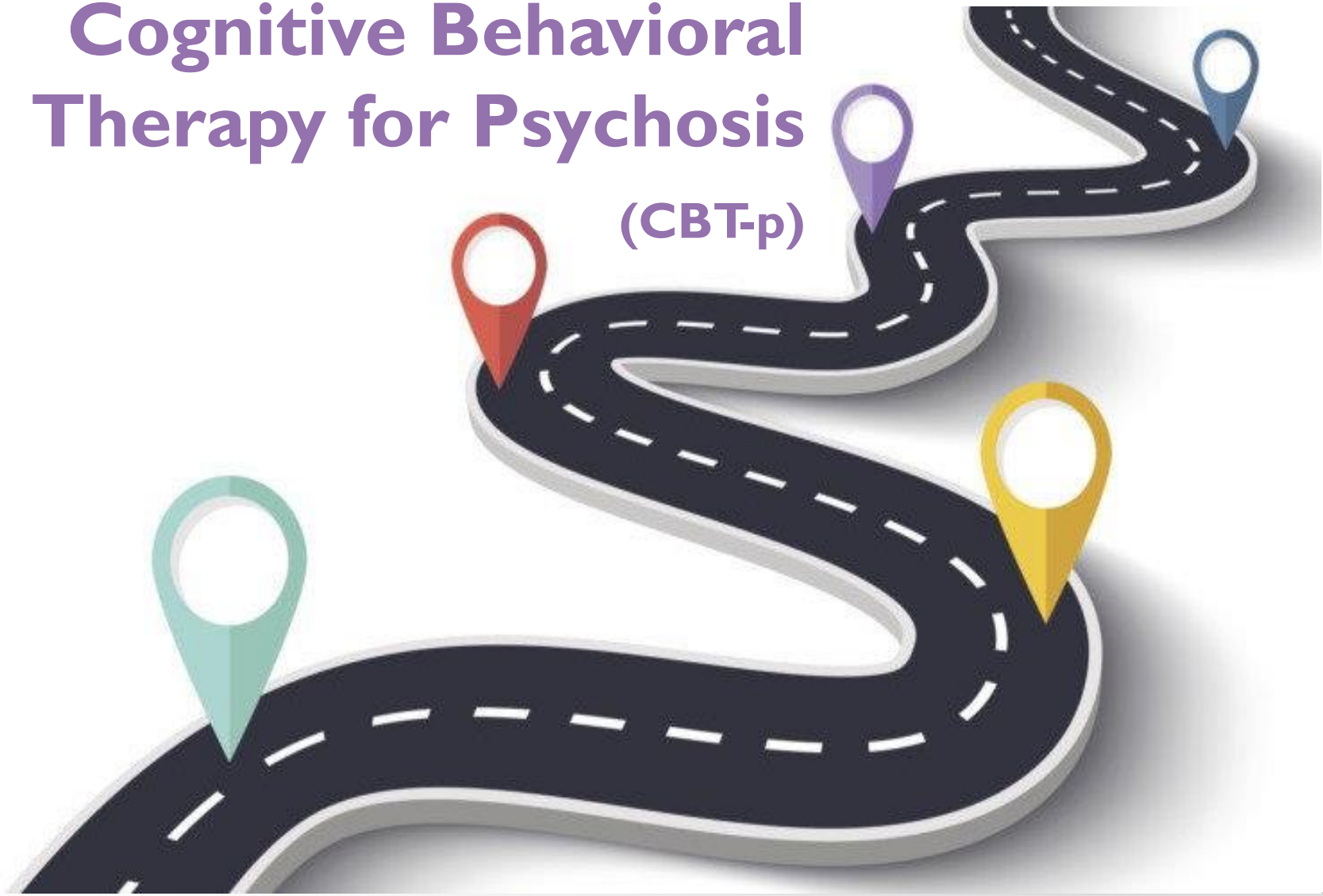
- Goals:
  - Increase the availability and access to services that focus on adult clients' family systems
  - Engage loved ones more strategically and proactively in client care
  - Improve inpatient-to-outpatient coordination by creating a seamless system of care centered on proactive family education and support and close care coordination
  - Decrease re-hospitalization rates (thus decreasing overall costs of care);
  - Improve communication and problem-solving skills among individuals and their family/natural supports
  - Benefit all members of a treatment team: the client, family/natural supports, and providers

REFERENCE

- Hupp, D.R. (2021). A Guidebook for Loved Ones Involved in a Network of Care (LINC). Best Practices in Schizophrenia Treatment (BeST) Center, Northeast Ohio Medical University, Rootstown, Ohio.

Cognitive Behavioral Therapy for Psychosis

(CBT-p)



BEST PRACTICES IN SCHIZOPHRENIA TREATMENT CENTER
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ESSENTIAL FEATURES OF CBT[1]

Therapeutic alliance

Action-oriented and collaborative

- Guided Discovery/Socratic Dialogue for learning
- Individual's goal orientation for direction
- Feedback loops encouraged in order to individualize the approach

Formulation-driven

Structure to sessions and time-limited

Use of a variety of cognitive and behavioral strategies

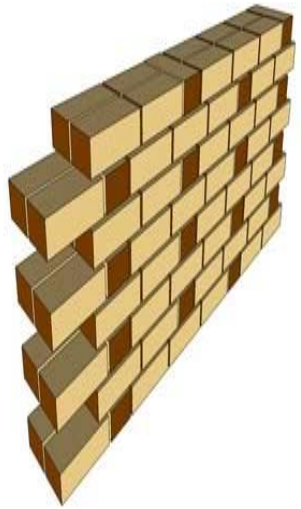
Use of homework to generalize skills

RECOVERY ENHANCEMENT PRACTICES IN CBT-p[12]

- View schizophrenia/psychosis with a **recovery mindset**
  - Hope and Optimism
- Develop a **trusting relationship**
  - Build from strengths, interests, values
- Approach all concerns with an **open and curious** mind
- **Teach and learn together**
  - Provide information that normalizes experience (to address stigma)
  - Show how cognitive model helps one understand experience
  - Solve challenges together: Shared decision-making!

REMEMBER, THERE MAY BE A GAP IN PERSPECTIVES

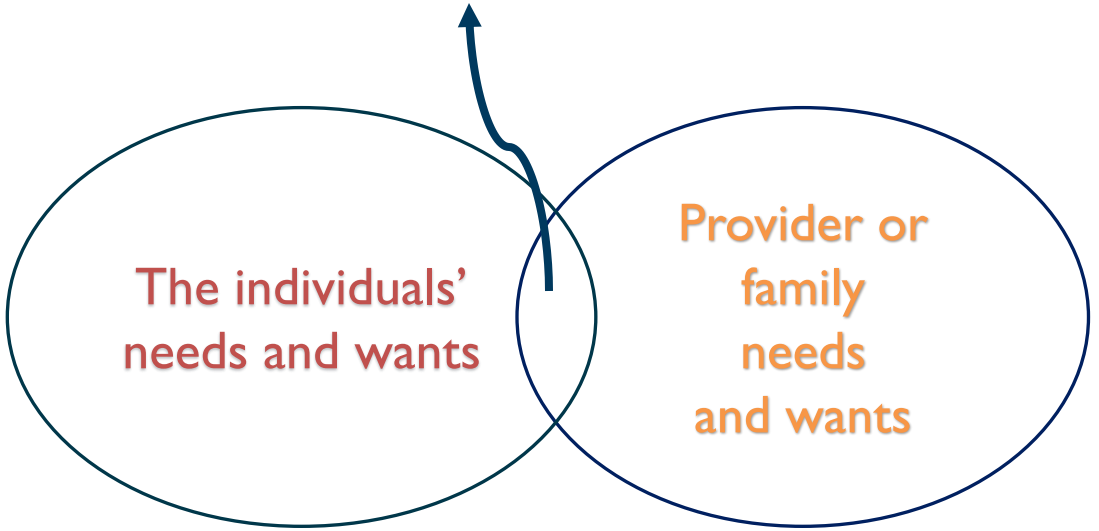
Individual's perception: "I'm not ill"



Provider or family/natural supports' perception: "You need help"

ENGAGEMENT IS ABOUT FINDING COMMON GROUND

Find the Common Ground: a meaningful value, aspiration, or goal



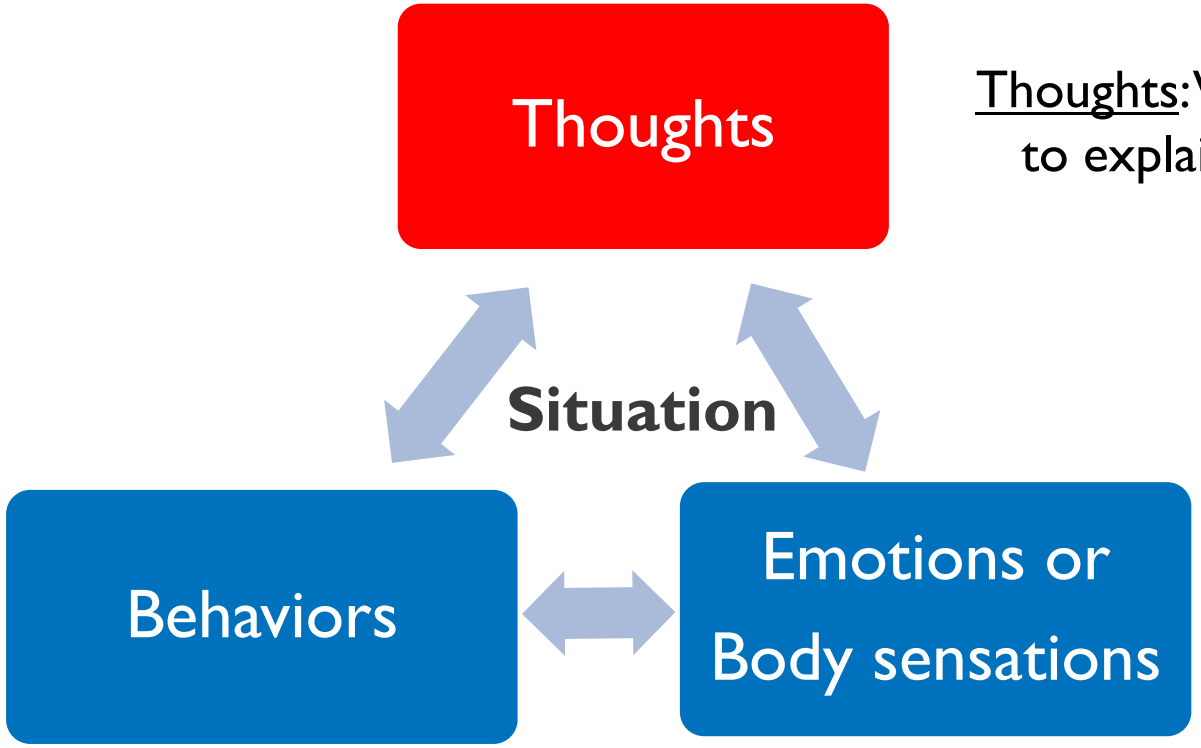
CBT-p GOALS

- Reduce distress and impairment
- Promote empowerment and recovery
- Use skills to progress toward personal, valued goal(s)

ADDITIONAL GOALS OF CBT-p

- Foster a curious attitude about symptoms/experiences
- Adopt "living with symptoms" strategy
- Move from "W*hat's the matter <u>with</u> you?*" to "***What matters <u>to</u> you***?"[2]

COGNITIVE MODEL

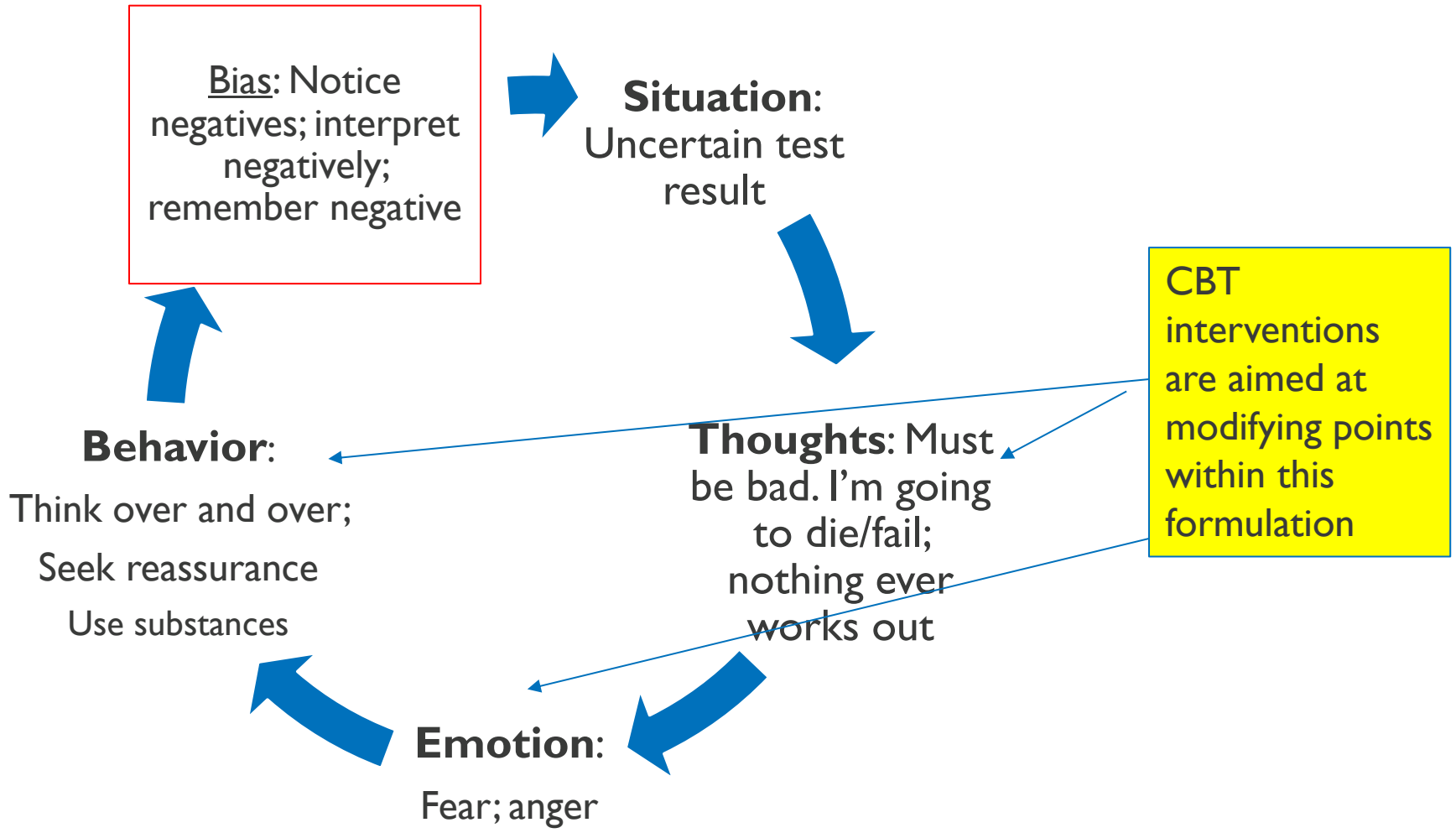


Thoughts: Words or images that are used to explain an experience or situation

Behaviors: What is happening, where, when, and how we respond to that situation

Emotions: Physiological responses to stimuli; A feeling is a label we give an emotion

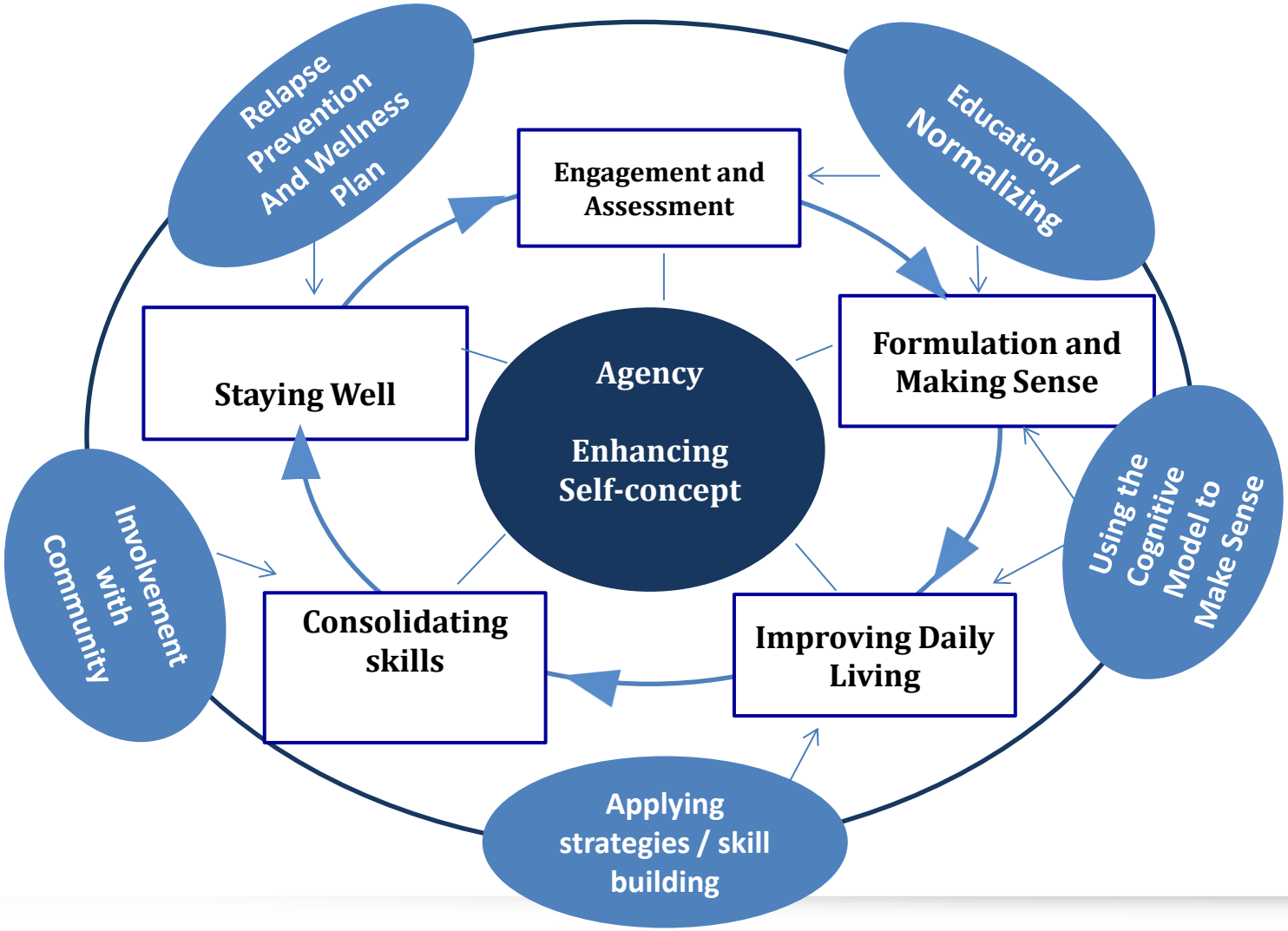
HOW STRESSFUL SITUATIONS BECOME SUFFERING



INTERVENTIONS ARE COLLABORATIVE EFFORTS TO:

- Learn new ways to make sense of distressing experience
- Learn ways to lower distress- coping strategy enhancement
- Learn strategies to test beliefs and slowly move toward personally meaningful goals

SUMMARY OF PHASES IN CBT-p[3,4,5]



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CBT-p SUMMARY

- CBT-p offers a modest but meaningful benefit in managing symptoms[6,7]
- Benefits demonstrated across numerous studies[8]
- CBT-p is a recovery-oriented treatment[9,10]
  - Well-being and personal recovery are primary focus
- Individuals are very satisfied with CBT-p[11]

REFERENCES

- [6]Burns, A., Erickson, D., Brenner, C. (2014). Cognitive-behavior therapy for medication resistant psychosis: A meta-analytic review. *Psychiatric Services, 65*, 874-880.
- [2]Deegan, P. Common Ground Academy
- [9]Freeman, et al., (2014). An early Phase II randomized controlled trial testing the effect on persecutory delusions of using CBT to reduce negative cognitions about the self: The potential benefits of enhancing self-confidence. *Schizophrenia Research, 160*, 186-192.
- [1]Hardy, K. Cognitive Behavioral Therapy for Psychosis (CBTp). https://www.nasmhpd.org/sites/default/files/DH-CBTp_Fact_Sheet.pdf

REFERENCES

- [4]Kingdon, D. G., & Turkington, D. (2005). Cognitive Therapy of Schizophrenia. New York, NY: Guilford Press.
- [11]Lawlor, C., Sharma, B., Khondoker, M., Peters, E., Kuipers, E., Johns, L. (2017). Service users' satisfaction with cognitive behavioral therapy for psychosis: Associations with therapy outcomes and perceptions of the therapist. *The British Journal of Clinical Psychology,* 56, 84-102.
- [5]Lysaker, P.H. and Roe, D. (2016). Integrative Psychotherapy for schizophrenia: Its potential for a central role in recovery-oriented treatment. *Journal of Clinical Psychology, 72*, 117-122.
- [10]Peters, E., et al., (2015). The long-term effectiveness of cognitive behavior therapy for psychosis within a routine psychological therapies service. *Frontiers in Psychology, 6*, 1-11. Doi: 10.3389/fpsyg.2015.01658.

REFERENCES

- [12]Sivec, H.J. & Kreider, V. (internal manuscript, 2021). Recovery Enhancement Practices for Psychosis (REP): A treatment approach informed by Cognitive Behavioral Therapy for Psychosis. A mental health providers guide to working with Psychosis and REP fidelity tool. BeST Center, NEOMED.
- [8]Turner, D., Burger, S., Smit, F., Valmaggia, L., van der Gaag, M. (2020). What constitutes sufficient evidence for case formulation-driven CBT for Psychosis? Cumulative Meta-analysis of the effect on hallucinations and delusions. *Schizophrenia Bulletin, 46*, 1072-1085.
- [7]Van der Gaag, M., Valmaggia, L.R., Smit, F. (2014). The effects of individually tailored formulation-based cognitive behavioural therapy in auditory hallucinations and delusions: A meta-analysis. *Schizophrenia Research, 156*, 30-37.
- [3]Visual model from BeST Center Manual.

Integrated Care

BEST PRACTICES IN SCHIZOPHRENIA TREATMENT CENTER
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INTEGRATED CARE

- The systematic linkage of mental health and primary care for the purpose of addressing the whole person's health care needs in a coordinated way that improves health outcomes[1]
- Requires communication or coordination between professionals and systems to meet all the health needs of the person, no matter where they seek care

WHY INTEGRATE CARE?

- Because individuals with serious mental illness (SMI) and/or substance use disorders suffer markedly worse physical health outcomes and have shorter lifespans due to those outcomes
- Persons with SMI engage in higher risk behaviors (e.g., smoking, substance use, lack of physical activity, poor diet) at higher rates than the general population and are often exposed to a higher rate of adverse social drivers of health
- Side effects of psychiatric medications are well documented (e.g., glucose dysregulation, weight gain)

WHY INTEGRATE CARE?

- Community mental health system has become the de facto primary care system
- Persons with SMI engage primary care and preventive medicine less and are more likely to experience poor-quality medical care overall
- Primary care clinicians may lack knowledge/training on how to best treat mental illness
  - But they can learn to effectively treat mild to moderate symptoms of mental illness (resulting in better division of labor across the system)
- Effective management of chronic disease requires effective management of co-occurring behavioral health issues

INTEGRATED CARE MODELS IN OUTPATIENT MENTAL HEALTH CENTERS PRODUCE POSITIVE OUTCOMES[3,4,5]

- Increased access to primary care and primary care utilization
- Reductions in ED visits
- Increased receipt of preventive health care
- Increased screening and monitoring of physical health conditions
- Improved monitoring of metabolic side effects of psychiatric medications
- Reduction in cardiometabolic risk factors
  - Improvements in blood pressure control, weight, body mass index, triglycerides, blood pressure control, total cholesterol, LDL cholesterol, tobacco use[6]

CHALLENGES TO INTEGRATING CARE

- Location
- Practice culture
- Financing
- Communication

LOW HANGING FRUIT & HIGH-REWARD IDEAS

- Universal screening (physical and mental health risk factors)
- Monitoring and treatment of the metabolic side effects of psychiatric medications
- Peer support and training in self-management skills
- Telehealth technology (if physical co-location isn't possible)
- Intentional teamwork
- Cultural humility (with patients and one another)
- Social Care

REFERENCES

- [1]Bagalman, E., Dey, J., Jacobus-Kantor, L., Stoller, B., West, K.D., Radel, L., Schreier, A., Rousseau, M., Blanco, M., Creedon, T.B., Nye, E., Ali, M.M., Dubenitz, J.M., Schwartz, D., White, J.O., Swenson-O'Brien, A.J., Oberlander, S., Burnszynski, J., Lynch-Smith, M., ... Haffajee, R.L. HHS Roadmap for Behavioral Health Integration (Issue Brief). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. September 14, 2022. https://www.hhs.gov/about/news/2022/12/02/hhs-roadmap-for-behavioral-health-integration-fact-sheet.html
- [4]Breslau, J., Leckman-Westin, E., Yu, H., Han, B., Pritam, R., Guarasi, D., Horvitz-Lennon, M., Scharf, D., Pincus, H., & Finnerty, M. (2018). Impact of a mental health based primary care program on quality of physical health care. *Administration and Policy in Mental Health and Mental Health Services Research, 45*(2), 276-285. doi: 10.007/s10488-017-0822-1

REFERENCES

- [6]Fortuna, K., DiMilia, P., Lohman, M., Cotton, B., Cummings, J., Bartels, S., Batsis, J., & Pratt, S. (2020). Systematic review of the impact of behavioral health homes on cardiometabolic risk factors for adults with serious mental illness. *Psychiatric Services, 71*(1), 57–74. doi: 10.1176/appi.ps.201800563 https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201800563
- [3]McGinty, E., Presskreischer, R., Breslau, J., (2021). Improving physical health among people with serious mental illness: The role of the specialty mental health sector. *Psychiatric Services, 72*(11), 1301-1310. doi: 10.1176/appi.ps.202000768
- [5]Scharf, D., Eberhart, N., Schmidt Hackbarth, N., Horvitz-Lennon, M., Beckman, R., Han, B., Lovejoy, S., Pincus, H., & Burnam, M. (2014). Evaluation of the SAMHSA primary and behavioral health care integration (PBHCI) grant program: Final report. RAND Health Quarterly, 4(3):6.

Cognitive Remediation

COGNITIVE REMEDIATION (CR)

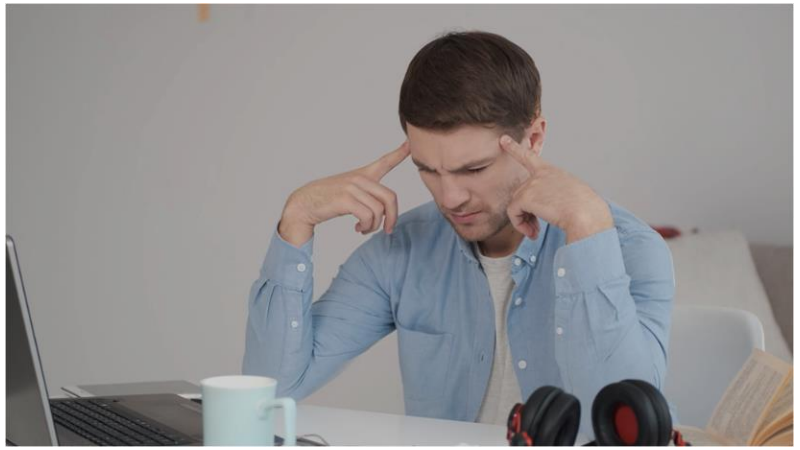
"By focusing on cognitive health in addition to mental health, cognitive remediation seeks to improve critical thinking skills, enabling people to be more effective in their daily lives and pursue their goals for recovery in a purposeful and meaningful way."[3]

- Action-Based Cognitive Remediation (ABCR)[1]
- Cognitive Enhancement Therapy (CET)[2]

WHY WE NEED CR

Deficits in **Cognition** (information processing, memory, attention, learning, executive functioning, etc.) are prevalent in psychosis/serious mental illess[1]

- Lack of independence[5]
- Difficulty with education[5]
- Difficulty with employment[5]
- Problems in relationships[5]
- Link to lower quality of life[1]

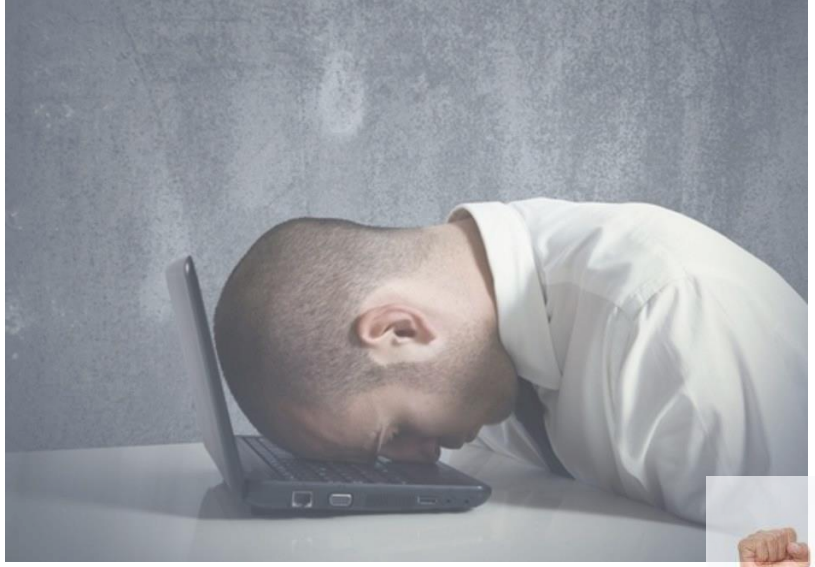


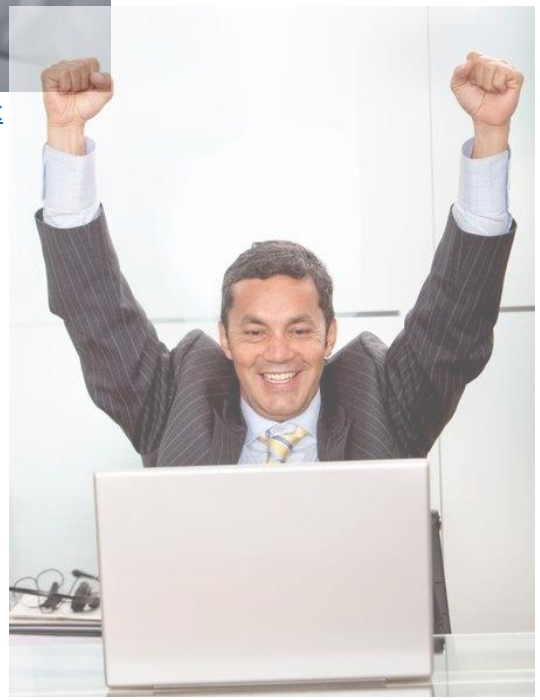
CORE COMPONENTS OF CR[1]

- Didactic Introduction
- Cognitive Training
- Strategy Monitoring
- Real-World Simulation
- Transfer to real-world / bridging

GOALS OF CR[1]

- Process
- Strategies
- Flexible thinking
- Experiment
- From "failure" (bad) to challenge (good)
  - *"It's not that I can't do it, it's that my approach did not work."*





ACTION-BASED COGNITIVE REMEDIATION (ABCR)

WHAT IS ACTION-BASED COGNITIVE REMEDIATION (ABCR)?

- ABCR is an 8-week, 16-session, manualized group-based intervention for remediating neurocognitive and social cognitive deficits in individuals with psychosis[7]
  - Computer training + the use of strategies with everyday activities to promote the transfer of cognitive improvement to the participants' daily lives[8]
  - Hopes to increase the likelihood that cognitive gains will improve quality of life[8]

HOW DO WE KNOW ABCR WORKS?[1]

- Independent and community living skills
- Increases in self-confidence
- More likely to be employed
  - Decrease in job related stress

WHO IS APPROPRIATE FOR ABCR?[9]

- A schizophrenia, schizoaffective disorder, or a mood disorder with psychotic features diagnosis
- Ability to read and write
- Age of 18 or older
- No substance use that seriously affects performance
- Willing and able to consistently attend scheduled group meetings

COGNITIVE ENHANCEMENT THERAPY (CET)

WHAT IS COGNITIVE ENHANCEMENT THERAPY (CET)?[10]

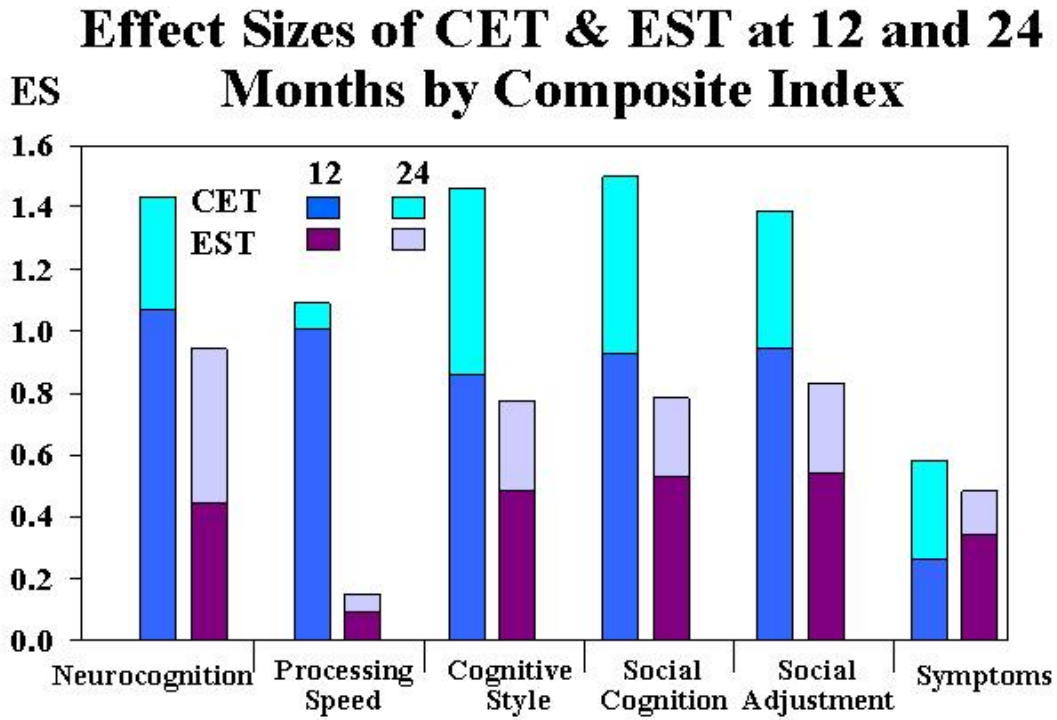
- An 18-month recovery-phase intervention for remediating neurocognitive and social-cognitive deficits in schizophrenia
- Increase mental stamina, active information processing and the spontaneous negotiation of unrehearsed social challenges
  - Enhance perspective taking, social context appraisal and other social cognition components

WHAT DOES CET LOOK LIKE?[10]

- **Neurocognitive Training**
  - 60 hours of computer-based training in attention, memory, and problem-solving
- **Social-Cognitive Group Therapy**
  - 45 group sessions - development of social wisdom and success in interpersonal interactions
  - Training in perspective-taking, gistfulness, non-verbal communication, emotion perception, etc.
- **Individual Coaching**
  - Non-group issues, homework, tailoring treatment and developing and updating recovery plan

HOW DO WE KNOW CET WORKS?[10]

- 30 years of research and counting!
- CET has been shown to have remarkable and enduring effects in a two-year randomized study

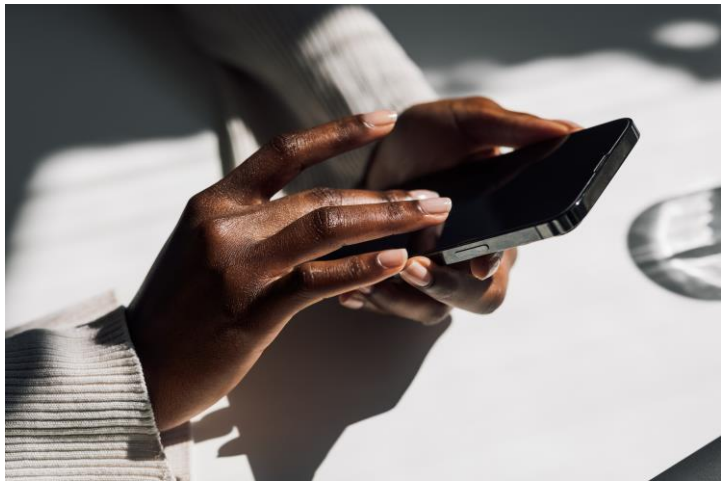


WHO IS APPROPRIATE FOR CET?[10]

- A schizophrenia or schizoaffective disorder diagnosis
- Symptomatically stable
- Medication and treatment adherence
- 6th grade reading level
- Age of 16 or older
- No substance use that seriously affects performance
- Agreeable to group sessions being monitored or recorded
- Willing to make an 18-month commitment

COGNITIVE ADAPTIVE APPROACHES[11]

- Reminders
- Tools
- Structuring the environment
- Preparing for challenges
- Accommodations at work or school



REFERENCES

- [9]Bowie, personal communication. August 31, 2022.
- [1]Bowie, C.R. (August 10, 2020). *Action Based Cognitive Remediation (ABCR)* [Webinar].
- [2]Eack, S.M., Hogarty, G.E., Cho, R.Y., Prasad, K.M., Greenwald, D.P., Hogarty, S.S. Keshavan, M.S. (2010). Neuroprotective effects of cognitive enhancement therapy against gray matter loss in early schizophrenia: Results from a 2-year randomized controlled trial. *Archives of General Psychiatry, 67*(7), 674-82.
- [10]Hogarty, G. E., Greenwald, D. P., & Eack, S. M. (2006). Durability and mechanism of effects of cognitive enhancement therapy. *Psychiatric services (Washington, D.C.)*, *57*(12), 1751–1757. https://doi.org/10.1176/ps.2006.57.12.1751
- [7]Kidd, S.A., Herman, Y., Virdee, G., Bowie, C.B., Velligan, D.I., Plagiannakos, C. and Voineskos, A. (2020). A comparison of compensatory and restorative cognitive interventions in early psychosis. Schizophrenia Research: Cognition, 19. https://doi.org/10.1016/j.scog.2019.100157.

REFERENCES

- [3]Medalia, A. (2022). Columbia University Department of Psychiatry. Retrieved March 23, 2022, from https://www.columbiapsychiatry.org/profile/alice-medalia-phd.
- [5]Medalia, A. (2002). Dealing with Cognitive Dysfunction associated with psychiatric disabilities: A Handbook for Families. *New York State Office of Mental Health*. Retrieved March 18, 2022, from https://omh.ny.gov/omhweb/cogdys_manual/cogdyshndbk.pdf.
- [8]Ott CV, Vinberg M, Kessing LV, Bowie CR, Forman JL, Miskowiak KW. Effect of Action-Based Cognitive Remediation on cognitive impairment in patients with remitted bipolar disorder: A randomized controlled trial. Bipolar Disord. 2021;23:487–499. https://doi.org/10.1111/bdi.13021
- [11]Velligan, DI (2000). Cognitive Adaptation Training: The Use of Compensatory Strategies in the Psychosocial Rehabilitation of Patients with Schizophrenia. (Manual for therapists). UTHSCSA, Department of Psychiatry.

RECOVERY!

RECOVERY IS…

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential

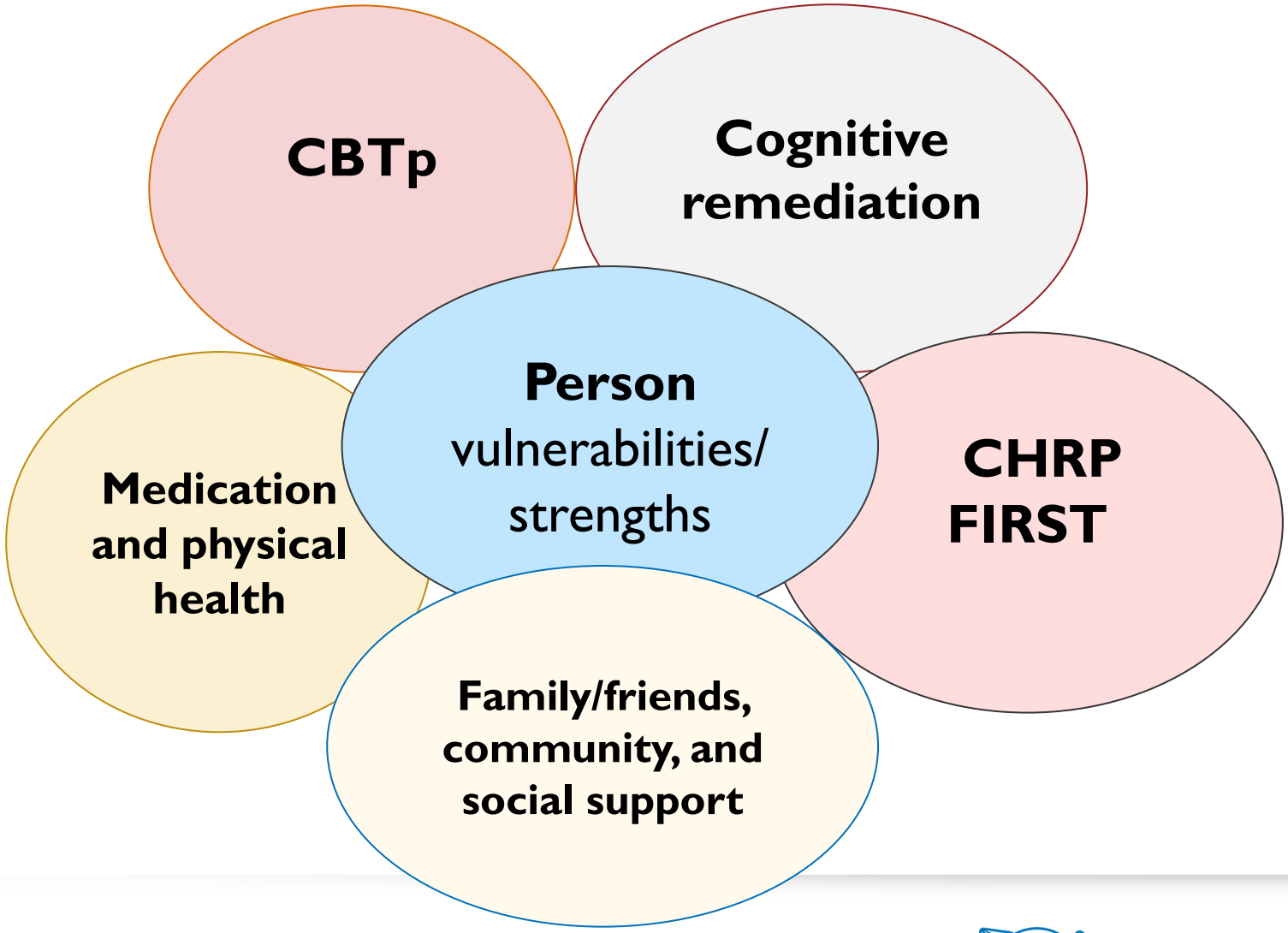
SAMHSA's working definition of recovery[1]

POTENTIAL BARRIERS[2]

- Socioeconomic disadvantages
- Distrust of traditional mental health services
- Pathologizing of cultural beliefs or legitimate social concerns
- Lack of culturally diverse teams

OVERCOMING BARRIERS TO ACCESSING SERVICES

AN INTEGRATED TEAM APPROACH



OTHER WAYS TO OVERCOME BARRIERS

- Adress and reduce stigma[3]
- Diversify outreach approaches
- Better communication and coordination with individuals, family/natural supports, and systems of care/providers
- Improve advocacy efforts
  - More resources – money and workforce support
  - Increasing joy in work
- Maintain hope
  - **Recovery is the expectation!**

RECOVERY HAPPENS!

- Individuals recovering from psychosis experiences can do anything they want to in their lives
  - Finish school
  - Go to college – and graduate
  - Get a good job
  - Have meaningful relationships
  - Enjoy life
  - Enjoy hobbies and special interests
  - Become independent
  - Be an active member of a family
  - Develop friendships
  - The list goes on!

SHARE THE GOOD NEWS!

REFERENCES

- [2]Jones, N., Kamens, S., Oluwoye, O., Mascayano, F., Perry, C., Manseau, M., & Compton, M.T. (2021). Structural disadvantage and culture, race, and ethnicity in early psychosis: International provider survey. *Psychiatric Services, 72*(3), 254-263. doi: 0.1176/appi.ps.202000211
- [3]Kular, A., et al. (2019). Stigma and access to care in first-episode psychosis. *Early Intervention in Psychiatry, 13*, 1208-1213
- [1]SAMHSA's Working Definition of recovery (from Substance Abuse and Mental Health Services Administration, 2006). National consensus statement on mental health recovery. Rockville, MD: US Department of Health and Human Services. Accessed online Aug 2015 http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF

ADDITIONAL RESOURCES

- **Ohio Certified Peer Supporters**
  https://mha.ohio.gov/community-partners/peer-supporters
  - Adult
  - Youth
  - Family
    - https://namiohio.org/family-peer-support/

RESOURCES FOR PROVIDERS

Ohio Systems of Care (SOC) ECHO for Youth Involved with Multiple Systems

- Ideal forum for addressing the complex needs of children, youth, and families served by Ohio Systems of Care for youth involved with multiple systems
- A public service offered by Best Practices in Schizophrenia Treatment (BeST) Center at NEOMED, Center for Innovative Practices at Case Western Reserve University, Ohio Colleges of Medicine Government Resource Center, Ohio Department of Developmental Disabilities, Ohio Department of Medicaid and Ohio Department of Mental Health & Addiction Services
- Learn more at: https://socohio.org/soc-echo
- Register at: https://iecho.org/public/program/PRGM1713974538045ODNZAWZZNR

BEST PRACTICES IN SCHIZOPHRENIA TREATMENT CENTER
A NEOMED CCoE

Northeast Ohio MEDICAL UNIVERSITY

RESOURCES FOR PROVIDERS

Ohio Alcohol Use Disorder/Substance Use Disorder Project ECHO

- Health care professionals will learn about identification, trends, implementation practices, and more while they share cases and network with colleagues across the care spectrum
- The Ohio AUD/SUD ECHO is funded through an earmark to train physicians and care teams in best practices for alcohol and other substance disorders
- Register at: https://iecho.org/program/PRGM169945383246 8D964KDSQU5/details
- Visit www.neomed.edu/SUDeducation or email SUDeducation@neomed.edu for more information on additional substance use education initiatives at NEOMED

RESOURCES FOR PROVIDERS

Deflection ECHO

- A virtual learning community that provides a health-facing response to substance use that engages, deflects, and supports strong community partnerships
- This collaborative focuses on bringing justice and treatment systems together for supportive community outcomes. Law enforcement, medical responders, addiction treatment providers, peers, and individuals with lived experience partner to work together to bring evidence-based solutions to substance use crises.
- A public service offered by the Criminal Justice Coordinating Center of Excellence (CJCCoE) in NEOMED's Department of Psychiatry through American Rescue Plan Act funding awarded by the Office of Criminal Justice Services
- Register at: https://iecho.org/program/PRGM169755279569001SGSBE8B7/detail

RESOURCES FOR PROVIDERS

Integrated Care at NEOMED (IC@N) TeleECHO

- **Interprofessional** / multidisciplinary support on real cases and situations encountered in practice
- Register at: iecho.org

Integrated Care at NEOMED (IC@N) TeleECHO

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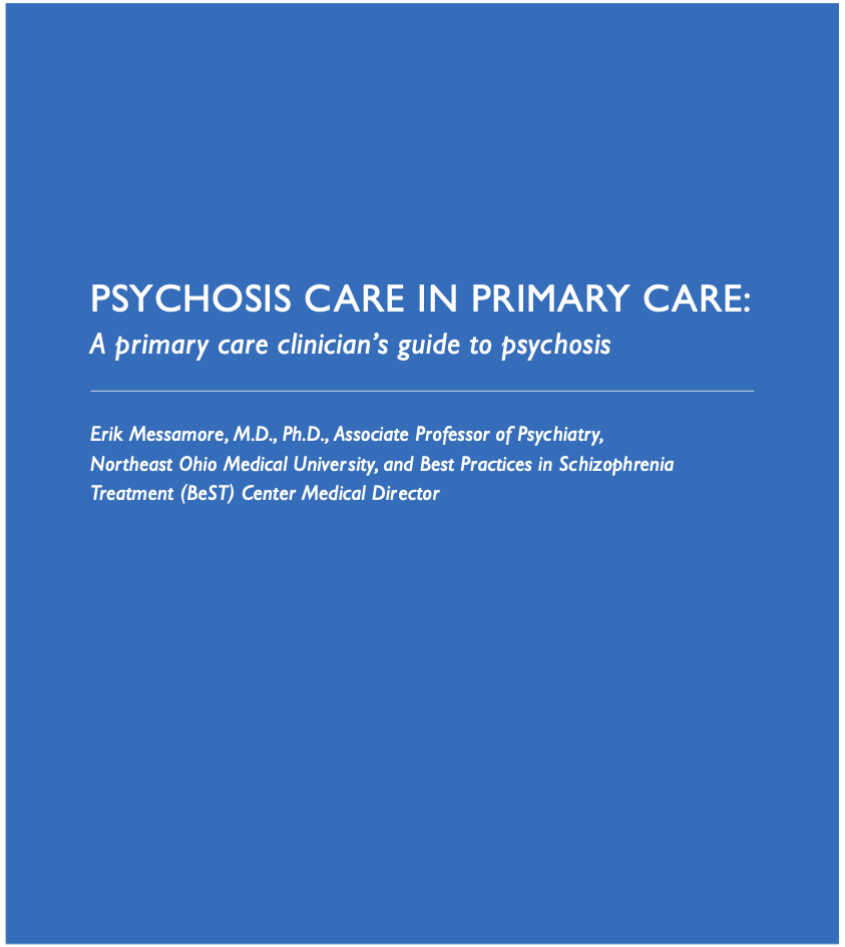
A NOTE ABOUT PROJECT ECHOs

- The above Project ECHOs are open to anyone working professionally in mental health (including substance use treatment), physical health, and/or integrated mental and physical healthcare.
- Individuals living with mental health conditions and their family/natural supports are able to view recorded informational didactics from Project ECHOs at:
  www.youtube.com/@NEOMEDProjectECHO

LAB TESTS FOR MEDICAL DISORDERS

- Complete lists of suggested lab tests appear in *Psychosis Care in Primary Care*
- Free PDF upon request; email bestcenter@neomed.edu
- Download PDF



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To learn more:

If you are interested in learning more or potentially bringing a BeST Center program to your area/organization, contact us at:

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