

Title: Assessing and Treating First-Episode Psychosis to Improve Functional Outcomes

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Some important points before we get started. Drs. Julie McCarthy and Rakesh Karmacharya, the presenters of today's webinar, work at McLean Hospital. As such, they have both a financial and intellectual interest in the webinar content. The purpose of this presentation is to provide a balanced view on assessing and treating first episode psychosis. APA does not endorse any products or services. The content was created by McLean Hospital and does not reflect the views of APA or its editorial staff. If you'd like more information, you can email advertising@apa.org.

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A recording of this presentation will be emailed to everyone in two weeks' time, and the recording will also include the presentation slides. During our time together today, you'll be on mute, and you can communicate with us using the Q&A box located on your webinar screen. If you have a question for our presenters, type them in that Q&A box, and we will get to those towards the end of the webinar. A link to the presentation slides will also be posted in the chat box of your webinar screen. Then if you miss them, don't worry, we'll also email those to you when we send the recording.

Now let me introduce today's presenters. First, Dr. Julie McCarthy. Dr. McCarthy, PhD, is a clinical scientist in the Division of Psychiatric Disorders at McLean Hospital. Her research aims to identify neurobiological and psychosocial treatment targets, and develop, evaluate treatments for individuals and families experiencing co-occurring psychotic and substance use disorders. As a clinical psychologist, Dr. McCarthy specializes in evidence-based treatments like cognitive behavioral therapy for individuals with schizophrenia, depression, and anxiety, and for families who are interested in helping someone with addiction.

Dr. Rakesh Karmacharya. Dr. Karmacharya, MD, PhD, is working at the intersection of chemical biology and stem cell biology to investigate the cellular and molecular underpinnings of schizophrenia and bipolar disorder, using patient-specific stem cells to generate human neuronal cultures. Dr. Karmacharya is a Medical Director of McLean OnTrack, the Director of Stem Cell Research at MGH Center for Experimental Drugs and Diagnostics, and Associate Professor of Psychiatry at Harvard Medical School.

Welcome, Drs. McCarthy and Karmacharya.

[pause 00:03:14]

Dr. Rakesh Karmacharya: Thank you for attending this webinar. I will start off with giving a little bit of an overview of how we assess first episode psychosis, how we approach both the evaluation and the treatment, and we'll focus a little bit on the goals of first episode psychosis, really focusing on functional outcomes. At the end, we'll leave some time so that you can ask us questions about some of the things that we cover.

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What is first episode psychosis? Psychosis is not a diagnosis, it's a constellation of symptoms, and it's usually a break from reality. Oftentimes, people come in with delusions, often with a paranoid flavor. They have hallucinations, tends to be much more in the auditory realm. They'll hear voices when there's no one around. They also may have constellation of symptoms, including disorganization in terms of their behavior, in terms of their thought patterns. Sometimes they come with catatonia. Again, every once in a while, we'll see negative symptoms, which is, again, the lack of things that we normally have in life, like motivation, the ability to feel joy, and poverty of speech.

What makes first episode psychosis often devastating, is it takes place in the prime of people's lives, usually in their late teens, early 20s. We define first episode psychosis as the onset of psychosis within the last one to three years. Again, as I said, it tends to be in the mid-teens to early adulthood, sometimes going up to even the early 30s. There is a subset of patients who will have psychosis later in life, but that is more the exception than the rule.

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We often hear a psychotic disorder as diagnosis. In the beginning, when you have a psychotic episode, it's often hard to tell what their eventual diagnosis will be. By going to the DSM criteria, there are certain specific criteria for the different diagnosis. If you have more than six months of psychosis, as well as functional decline that goes with it, we put that in the category of schizophrenia.

There are people who also have a strong affective component as well. They have prominent mood symptoms. If you have psychosis without mood symptoms, but also have episodes where you do have mood symptoms, then we categorize them as schizoaffective disorder.

Then there are people who primarily have a mood disorder, but also have psychosis in the context of their mood episodes. For example, you have a bipolar patient who gets manic, but gets very psychotic during that. We put them in the category of bipolar disorder with psychotic features, or major depressive disorder with psychotic features.

Then there are people who in some ways have milder form. They only have delusions that are not bizarre, but they're very fixed delusions that, again, is a break from reality, and we call them delusional disorder.

While a lot of these tend to go on for months, there are people who do have these brief psychotic disorders, or what we call schizophreniform disorders where the

episodes are not very long. They're pronounced, but they are either, if they're less than a month, we categorize them as brief psychotic disorders. If they're within one to six months, we put them as schizophreniform disorder. They don't quite meet the criteria for schizophrenia.

Initially when you come to a first episode, we usually would put them as Psychotic Disorder Not Otherwise Specified partly because the-- Unless there's clear reasons for us to believe their diagnosis is one or the other, we usually would put them under this unclear diagnosis, Psychotic Disorder Not Otherwise Specified. In the context of the treatment in a year or two, it becomes clear what their actual underlying diagnosis may be.

Again, these are a little bit more on the different criteria. I wouldn't dwell on it too much. This is, again, the DSM criteria for how you define. You have to have a certain number of categories on one or the other to meet criteria for schizoaffective disorder, schizophreniform, versus if you have bipolar disorder, MDD with psychotic features.

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What are not psychotic disorders? Not everything that looks like a psychotic disorder may not be a psychotic disorder. This especially comes in the context of when you see patients, especially in the hospital, they're coming with a neurological issue, or they're being treated for certain medical illnesses with certain medications that can give rise to conditions that look like psychosis. Those are more under the realm of delirium or medication-induced episodes that appear to be like psychosis.

There are people who have psychosis-like symptoms, but only in the context of substance use disorder. People who, for example, are using cocaine or LSD. They'll have this break from reality, but it's only in the context of when they're using the substance use.

The other ones where things will appear a little bit more nuanced, people who have PTSD will sometimes have these breaks from reality and have episodes that look very much like psychosis. I think something to keep in mind, people with significant trauma is putting that in the differential because the treatment for PTSD will not be the same as someone with first episode psychosis.

Similarly with OCD, there are people who have very severe OCD that often get in the realm of almost looking like it's a psychotic disorder. Again, psychosis is something that happens when someone is awake. It's also a culturally bound idea. There are some ideas that may seem so out of context in one culture, but may be the norm in a different culture. We have to keep that in mind as well when we think about is someone having a delusion or is this just a different way of looking at life in different belief systems.

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Why is early assessment psychosis important? Usually, there is a lag between when people start having symptoms and when they actually get treated. A significant goal for the community has been to try to decrease that duration. Because the longer you have an untreated duration of psychosis, the worse the outcomes. Currently, it's

usually almost a year-and-a-half before people end up getting treatment when they start having psychotic episodes. Again, there are a lot of studies that have shown that the shorter the duration of untreated psychosis, the better the quality of life in the long run, the better your negative symptom severity, which, again, is something that's much more important for functional outcomes in the long run, and even total symptom severity.

The difficulty with often accessing treatment, one is stigma. Psychosis is something that has a lot of stigma in society, and both patients, as well as families will try to avoid that, thinking that it is a psychotic episode, and will delay seeking treatment for it. The access to care is not uniform in our society, and for a lot of segments of society, seeking psychiatric treatment overall, and especially for specialized treatment for first episode psychosis, is not always easy to find.

The other one is lack of insight. When people are delusional, they have a different way of looking at things. For them to realize that this is an illness and not just a different way of thinking, is something that often is very difficult. Then we're dealing with people who are in their late teens, early 20s, at a developmental stage where they are individuating on their own and rebellious at times. For them to come to terms with what is going on and seek treatment, often is a significant barrier as well.

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What are the risk factors for psychosis? Again, it's a uniquely human disorder. As far as we know, there are no animals who get psychotic. From all the information we have so far, all the studies so far, there is definitely a strong biological and genetic component to it. It's not simple genetics. It's very complex genetics. It's a study indicating that there are probably a lot of genes that have very small contributions. It's the perfect storm when you have all this, the combination of those genes that gives rise to susceptibility for schizophrenia.

Again, genes and biology is not destiny. It just increases the risk and vulnerability for disorders. For instance, if you have identical twins with schizophrenia, one person has schizophrenia, the risk that the other one will have is 50%, which is a significantly higher risk than the general population, but it's not 100%. There are definitely strong gene environment interactions that are important for the manifestation of the disease.

There's also overlap between schizophrenia, schizoaffective disorder, and bipolar disorder as well, in terms of the genetic susceptibilities. There are definitely the environmental factors we talked about. The epidemiological studies show things like growing up in an urban area, migration, social isolation, childhood trauma. These are all things that potentially add to the environmental factors that can impinge on the underlying genetic risk to lead to disease.

The one that also comes up often is the pregnancy and birth complications, including maternal illness, viral illness during pregnancy. One of the things that often epidemiologic studies have shown is that if someone is pregnant during their late first trimester or early second trimester pregnancy, the risk of the child having schizophrenia later on in life increases. Again, with the caveat that they likely will have to have an underlying genetic vulnerability as well.

One specialty thing that has been increasing in the last decade or so that we often deal with is cannabis. Cannabis is definitely something that is a strong risk for psychosis, especially again for people who have underlying genetic risk. Oftentimes my conversation with the patient would be like, my patient would be like, "All my friends smoke marijuana. Why can't I smoke marijuana?" I said, "There are a lot of people who smoke marijuana and nothing happens to them. For people who do have this genetic susceptibility to psychosis and marijuana, they are very sensitive to marijuana." Many of the patients that I see would never have had a psychotic episode if they hadn't smoked marijuana on a regular basis.

Those are some of the things that we have been learning and trying to use that in both educating our patient and in trying to prevent, to a certain extent, the onset of first episode psychosis.

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Dr. Julie McCarthy: Thank you so much. Now you know a little bit about what to look for with psychosis, but how do we practically assess for psychosis? There's a few options to think about when considering the context that you're working in or the amount of time that you have with a client to make these assessments. The gold standard diagnostic interview that we would typically use would be the structured clinical interview for a DSM-5. This is an interview, if you haven't done it before, that might take one-and-a-half, two hours. It is a bit of an investment in time. However, it does allow you to properly diagnose psychotic disorders, and then also understand what might be happening by way of mood disorders that would help make some of those distinctions between bipolar disorder or major depressive disorder with psychotic features versus some of the schizophrenia spectrum disorders.

An alternative to that would be the mini-international neuropsychiatric interview, or just termed the mini, and this can be completed in somewhat less time, depending on how many symptoms someone might be endorsing. On the quickest end, maybe 45 minutes up to an hour or so.

Then if we're looking at how severe some people's symptoms are, either upon intake or over the course of time, we can use clinician-rated symptom scales like the brief psychiatric rating scale, which taps into a number of psychotic symptoms, as well as some related symptoms like depression and whatnot. The positive and negative syndrome scale for schizophrenia captures a wider array of symptoms, ranging from positive to negative, and also general symptoms as well.

Then for negative symptoms in particular, that can sometimes be harder to assess. The Clinical Assessment Interview for Negative Symptoms, or the CAINS, is one of the more recent clinician-rated symptom scales that gets at both the internal experiences of negative symptoms, like emotivation or anhedonia, and also behavioral manifestations of how that might lead to decreased goal-directed behavior or emotional expressivity in people's lives.

From a self-report questionnaire standpoint, which can be very useful if you don't have a ton of time to do a lengthy assessment for everyone and you're trying to flag those people who might warrant further assessment, the Prodromal Questionnaire, or PQ-16, is freely available online and can help to quickly assess who might need a

higher level of semi-structured interview later on. Usually people who need for at least six of those items might warrant further assessment.

Then the BASIS-24, if you're not familiar with that, it's the Behavior and Symptom Identification Scale. It's an assessment scale that really taps into a lot of different areas, and so there are a small handful of items that get at psychosis specifically, and it can be a great screener to use to quickly flag who might be experiencing a psychotic disorder.

When we think about engaging with people, whether we're using one of these formal assessments or talking to people on our own without a formal assessment, we can think about the language that we use to, one, avoid leading questions, and two, to try to use language that's as approachable as possible, because sometimes people can feel a bit uncertain or sometimes defensive when we start asking them about some of the symptoms of psychosis. For instance, instead of asking someone, "Have you been paranoid before?" we could say, "Has it ever seemed like people were talking about you or taking special notice of you?"

Another way that we can talk about auditory hallucinations, aside from, "Do you hear voices?" which people may or may not, we could ask something like, "Do you ever hear things that other people couldn't, such as noises or the voices of people whispering or talking?"

Also for negative symptoms, a lot of people may not know what that is, so we can ask more concretely something like, "Have you had any contact with friends in the past week?" which is getting at the asociality that might be happening, or socially anhedonia, perhaps. Beyond that, we can get a sense of, well, what does that contact look like, because that could be different for different people in terms of the type, the frequency, who's initiating that contact, versus if they're receiving that contact. Then also, if the contact has not occurred, we can ask a little bit about what might have been some of the barriers that could stand in the way. Because sometimes people might be fully interested in engaging in certain activities, but they may have difficulty logistically doing so.

For some of the assessment aspects that we would not explicitly ask about, we're thinking about what we might observe from the very first moment of contact, whether that be in a waiting room or in a phone screen, before we start meeting with people officially, and then during the sessions themselves. We can look for some of those disorganized symptoms that Dr. Karmacharya had mentioned.

Specifically, what I mean by that would be signs that there might be some disorganized thought process occurring. For instance, derailment or loose associations might be where people are jumping from one topic to another. If you're asking about how school is going, someone might respond by saying, "Yes, I went to school. My sister isn't speaking to me. Yes, the dog should go. I should have focused more on saving the world. Did you see that?" Having really unrelated topics of conversation all coming up at once, but the sentences themselves logically flow.

Tangentiality might be where someone starts with a particular topic, and they end up going off in a completely different direction and really don't circle back to where the topic had started.

Then incoherence or word salad is, even within a sentence or a string of speech, the words do not have a linear flow. For instance, "I blew car fly." That is something that we might deem word salad, where there's really no logical connection between the words, never mind sentences.

For Catatonia, we can be looking for things like stupor, where it's almost as though a person has been turned off in some ways. We're not seeing much psychomotor activity, not getting much responsiveness if someone tries to talk to them.

Posturing would be a little bit different, where it's almost like someone is stuck in some way, either in a rigid position where they are at rest, or sometimes maybe having an arm or a limb up in the air suspended in a way that seems out of the ordinary.

Stereotypy is something that could be both manifesting in terms of behavior, like repeated tapping of an object, different than OCD, where we might be tapping to reduce anxiety. Here, it really doesn't seem to have a purpose. Same with repeating the same word or phrase over and over.

Let's go through a case example and see how we might apply some of these criteria that we've discussed to a particular composite case. Let's say John is a 20-year-old male who started having trouble in his college courses, withdrew from his friends, and was vaping cannabis daily. He started talking to himself and posting on social media about his suicidal thoughts. His friends contacted his family about these concerns. His family spoke with him, and he said he would never hurt himself, but he was scared about people, or being able to hear people saying negative comments about him, even when he was alone. He's speaking with you as a provider for the first time. We can think for a moment together what else we would need to know to determine a diagnosis.

Some of the things we might want to think about would be the timing. When did these symptoms begin? Because as you may have noticed, to meet certain criteria, you need to have these experiences for certain amounts of time, usually on the order of less than a month, more than a month, or about six months or more. We also want to understand what other psychosis symptoms he might be experiencing. For instance, if he's just afraid of people saying negative comments, that alone wouldn't make sense for a full diagnosis of schizophrenia. However, if other things were going on, that could qualify, potentially. We also want to understand, has he met criteria for a mood episode? If so, that's something that we would also want to assess for differential diagnosis. We also want to understand, has he experienced psychosis outside of the mood episode and while sober?

Some additional information we might gather could include, John described starting to hear voices seven months ago. He shared that he ran out of money and couldn't buy vape cartridges for cannabis for a couple of months in the summer, leading him to not use. However, he reported that he still heard voices when he was not using cannabis. He said that he's only felt depressed, for the first time, one month ago. He attributed this to the stress of finals and having trouble feeling motivated to study or take care of himself.

John also notes that over the past year, he started to believe that he was meant to save the world. We can think, based on some of the options available to us, what is the most likely diagnosis. In this case, it's probably not cannabis-induced psychosis because there's been that couple of months where he was still experiencing persistent symptoms of psychosis without being under the influence of cannabis. Bipolar disorder with psychotic features wouldn't necessarily make sense here because the mood component that we're seeing is just the depression. It's possible that there could be some grandiosity with the belief that he was meant to save the world. In the absence of other symptoms, we wouldn't say that the mood was the most significant component of this past 7 to 12 months.

From a schizoaffective disorder standpoint, we've also seen that, yes, there might be some mood episode occurring recently, but it's not the majority of the time. Our most likely diagnosis would be schizophrenia in this case.

Now we'll talk a bit about treatment for first episode psychosis. The evidence-based approach, in an ideal world for first episode psychosis, is what's called Coordinated Specialty Care, or CSC. This is a collection of services delivered through a team-based approach, typically. That being said, if you're working in private practice outside of one of those contexts, you can still perform the psychotherapy components of Coordinated Specialty Care, either in consultation with other providers, or work on the same types of skills in your own practice.

The components that are included in CSC models are cognitive behavioral individual and or group therapy, medication management with a prescriber, family education and support, which we'll talk a little bit more about as well, case management that can be done by yourself or with a social worker, and also supported employment and education. Although the inclusion of peer specialists is not a requirement of CSC programs, it is something that's often included and can be really helpful for a number of folks.

To start off with CBT psychotherapy, many of you might already be very familiar with how we might approach this. In the context of care for first episode psychosis, we can think about doing a good assessment intake, and really identifying the initial needs and goals of the clients that we're working with. Providing some education about psychosis can really help because people might come in to a first episode psych clinic or work with you, and they may not fully understand what their psychotic disorder or psychosis experience really means. There's a lot out there in the media or online that may or may not be fully accurate. Really going through some of the criteria so people can understand what they might be experiencing can help when the conversations about different diagnoses end up on the table. Trying to talk about the stress management aspect of things can really help people mitigate the risk of future relapse.

We can also think about how to develop a wellness plan with people. In addition to thinking about perhaps reframing any unhelpful thoughts that people may have about themselves or stigma associated with having a psychotic experience, thinking about explicitly a wellness plan of risk factors for that individual that might make it harder for them to stay well, the coping skills that will keep them on track, and then also how their providers and their family members or other social supports in their network can play a helpful and supportive role in maintaining wellness or addressing support in a

crisis, or explicitly naming who they might not want involved in a crisis, can be very empowering to people to have advanced discussions before someone needs a higher level of care, potentially in the future.

We also certainly talk about addressing substance use if it's not clear to people already, really sending the message about this association between using substances, particularly cannabis, as increasing the risk for psychosis is helpful. Although it's not a guarantee that everyone who uses cannabis will develop further psychosis, we do know that it increases the risk of rehospitalization.

Improving relationships is really key, too. As we had mentioned in one of the case examples, starting to see that social isolation is something that can be a concern. Trying to rebuild those connections can really help.

We do this in session and including home practice, goal setting throughout, collaborating with different family members, maybe in the service of those goals, and really trying to empower people to make their own decisions. People may not be ready to engage in all the components of Coordinated Specialty Care, and so we can meet people where they're at, and we can also explore concerns around privacy and confidentiality, either with other family members being involved, or things like school and work as well.

I think, Dr. Karmacharya, could you unmute yourself? Thank you.

Dr. Karmacharya: I'll talk about the medication management for psychosis. Again, in almost all cases, medication is a key piece, especially in the early stages of a psychotic disorder.

Most of the time when patients come to our program, first episode program, they come after our hospitalization where they have been medication that have been used for the stabilization, oftentimes, on the more heavy side in terms of the antipsychotics that are being used.

The treatment approach for us in the first year or two is really trying to optimize the medication regimen in a way that is going to be something that will enable better functional outcomes in the long run. The medication that someone was put in the hospital during hospitalization may not be the one that they will need in the long run because there's a different set of medications and approaches you need during the time of an actual acute psychotic episode than what you need for maintenance and to avoid having episodes in the long run.

We do have a range of different options in terms of medication, some lighter, some heavier in terms of the side effect burden. Some people do need the more strong medications, and some people can get away with one that have fewer side effect, but also not as strong. That's part of the optimization that happens in the first year or two. From our perspective, we are trying to find what is the least harmful things we can get away with as we think about a medication regimen that the patient will do well in the long run.

In the medication we have, they primarily address positive symptoms like the hallucinations, the delusions, which the medications are much better at controlling

than issues related to negative symptoms and cognitive impairment, which are not as easy to treat with the medications. In the long run, those are the ones that affect the functional outcomes the most. These medications have significant side effects in terms of weight gain, the metabolic syndrome, sedation, extrapyramidal symptoms, tardive dyskinesia. One of the mistakes, from my perspective, that psychiatrists often make is really not trying to decrease the medication or change the medications. Because sometimes the psychotic episodes are so severe that as an outpatient, psychiatrists are often hesitant to decrease the dose or change the medications when they may be doing well on a less strong medication regimen. That's the trial that we do in our program, is really try to dial down the medication, change the medications so that not only are the symptoms under control, but they're actually able to lead meaningful lives.

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This is where I think the shared decision-making comes in. I am there as someone who is providing expert opinion, giving them guidance, but I have to meet the patient where they're at. The many varieties of psychosis that we see in terms of where patients are at, we're usually looking at patients in their late teens, early 20s with very different outlooks on life. There's some who are very, very scared of what happened. They're almost begging me not to take them off the medications that they came to me from the hospital, but they're sleeping 16, 18 hours a day. I'm like, "We will monitor you very closely, but we should try and see if we can decrease the dose, change the medications, to be able to actually function and go to class and do your things."

There are others who are very rebellious and say, "I don't want your effing chemicals." I usually tell them, "I don't get a cut from the pharmaceutical company. If you do well without the medications, I'll be the happiest, but let's keep meeting. Let's keep meeting every week, see how they're going. If there's anything that you're having problems with, we can try and adjust that." Really, I think meeting patients where they're at and trying to optimize the medications with the functional outcomes in mind, and involving the families whenever we can so that they can be part of the process, and both educating them about the medications, as well as the side effects, and what are the costs and benefits of each treatment that we may consider, and helping them make that decision.

I always tell the patients, "I can prescribe whatever I want. You can just flush it down the toilet. I have to get that buy-in from you to see that this is something that you feel would be right for you." Often, I think building that trust, building that relationship, I think it's a critical part of treating these patients early on in their illness.

The other part is also, I think, what you say, they really take to heart, in terms of what the long-term trajectory looks like. I think historically, **[inaudible 00:34:43]** talked about psychosis being this doom and gloom diagnosis. Once you have a psychotic episode, your life is never going to be the same. You've got to reorient and choose less stressful goals. Whereas we take a different approach and we call that program OnTrack because our goal is to get the patient back on track with their goals and aspirations. I often ask my patient, "If I had met you a year-and-a-half ago before all this happened, what were your goals? What did you want to do in the next 5 or 10 years? Is there any reason that has changed?" Just having had a psychotic episode

is not a good enough reason. Sometimes people do have a change of heart, but the goal that we work on is really trying to get them back on their feet and really back on track. What the patients themselves have shown to us over the years is that is an eminently reachable goal.

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Dr. McCarthy: Now I'll talk a little bit about family education and support. This can look like a number of different things. I think one of the first pieces to keep in mind is to think about this at all and bring it up with your clients. Because if you haven't had that much experience working with family members, it can feel intimidating to think about putting this on the table if you are newer to this, and also normalizing the fact that it can be helpful, can help clients see the value in including family members. What the education for families can include could be somewhat similar to the education that we might provide to clients about psychosis, medication, et cetera. Also thinking about how they can bolster their own effective communication with their loved ones, play a role in the wellness plan and collaborate in meaningful ways with professionals in ways that are also flexible with client needs.

Why this is so important is because certainly family members are often the folks who might be assisting a loved one getting in the door to treatment, to begin with. We know that having more warmth or positive affect in family members is associated with less relapse among people with schizophrenia spectrum disorders. When we talk to people who have psychosis and they think about, well, what works well with having family involved in care, it's not just being supportive of a particular treatment plan, it's really being supportive of their general wellbeing, really thinking more broadly about recovery.

Though every family is different, on average, having family involvement in first episode psychosis care is associated with better outcomes. One way we might be able to approach this involvement might be something like, "Hey, I know you talked about some concern with your family member. It can be useful to have them as part of the conversation to talk with them about how you'd like them to be more helpful. What do you think about having them join us for a family meeting?"

Then from a case management perspective, we can think about what are some of the needs that also need to be met in order for recovery to be as successful as possible? Sometimes the issue of housing comes up. If someone's coming off of an inpatient unit, they might need to figure out a place to live if that's not returning home with family, for instance. Also thinking about medical care. If people haven't already had as part of their assessment, a visit with a physician, that would be pretty important to also rule out any general medical conditions. Thinking about transportation can be key, even to getting to appointments. If you're seeing people in person, but they're having difficulty finding a ride to get to you or they're having difficulty affording public transportation, trying to find other options so that people can engage in the treatment that might be available to them is huge.

Then from the supported employment and education standpoint, this can be so important, one, because it's part of people's recovery goals. People may not just want to talk about reducing symptoms. It's really about getting back to school, graduating, getting a job, earning enough money to move out of the family home.

However, some of the challenges that people experience are in the cognitive domain that can complicate these life goals. Not everyone, however, on average, when people have a history of a schizophrenia spectrum or a psychotic disorder, they typically have more difficulty with concentration and attention, short-term or working memory, and processing speed. That, in combination with some of the negative symptoms that might be there, like anhedonia, not getting as much pleasure out of things or amotivation, which is tough, especially when you've got work that requires effort, school that requires studying, and also things like depression, or shame, or embarrassment, or concerns about disability benefits, it could provide a little bit more hesitation to getting going in these areas.

However, trying to work with someone who is a trained vocational specialist, or can help someone connect to their goals, employment and education-wise, can be really helpful to improve finance structure for that individual. It can improve how people think about their own identities and their contribution in life, and can really give hope, and can lead to greater independence, which is what most people want for themselves.

The way that this can look is a number of different things. You can do a bit of an inventory or assessment about people's histories, their involvements, their strengths that they're bringing to the table, what their current preferences are. From a practical standpoint, there can be assistance with the job applications, interviewing for positions, having letters of support to return back to school. Really thinking about what's needed for each case, and thinking about how we can not just give advice on how to get there, but provide practical support as well, can be key.

Then from the peer specialist perspective, again, this is the people who have lived experience, in this case, with psychosis, and they might be also what you call certified peer specialists who have gone through specific training programs to provide their lived experience support to others going through mental health recovery. They can be involved in outreach and engagement, helping to get people introduced to care if they're new or a little hesitant about meeting with a provider for the first time. They can also be helpful not only working with clients with psychosis, but also family members. For instance, we might have a peer specialist co-leading with a clinician, a family support group.

We can also think about peer specialists as being able to offer and share their own lived experience perspective with the others that they're working with in a non-clinical but supportive way to build understanding and normalize the fact that recovery is possible. Then they can create wellness toolkits with clients, and really also be a voice to advocate for the lived experience perspective, and encourage things like recovery-oriented language.

Now I'll end this presentation portion by talking a bit about how to improve functional outcomes within this context of care. Remembering the utility of using evidence-based approaches like Coordinated Specialty Care, using things like the Navigate Manual, for instance, that supports the research on coordinated specialty care, can help improve quality of life for clients.

Think about better treatment retention. If people are getting something out of treatment, they're more likely to stay in it until they no longer need it.

Symptoms can improve. Staying out of the hospital, which is always a good thing, can help. Also really thinking about how this can boost people's social and occupational goal attainment, is big. Then also from a more holistic perspective, thinking about overall better family well-being can really help not just the individual at the center of concern, but their whole social environment.

Some different ways we can think about this is, one, trying to get people in the door as early as possible. If you're not sure or if a client's not sure, doing an assessment to at least get the conversation started can help.

Also thinking about how we can improve treatment response in some ways speaks to needing to ask or evaluate about how that's going over time. There's this term, learning health care system, that's become newer, where it's essentially measurement-based care. You might already do some of this. If you don't, it's something to consider, having regular assessments that clients complete so that you and they can see what's changing, what's not changing over time. Also thinking about what are the things that are in our control as providers or as clients to move the needle on. We might not be able to change someone's genetic predisposition to psychosis. However, we can think about reducing behavioral components like using substances to at least decrease the chance of further symptom exacerbation to ultimately prevent relapse.

Other things that can help are addressing the stigma associated with mental health diagnoses. Even within that umbrella, schizophrenia and other psychotic disorders tend to carry a greater stigma relative to some of the other diagnoses that we may see. Stigma can come both in the form of public stigma in our society, negative beliefs about psychosis, also self-stigma, or that internalized belief about what people may not be capable of, that people with lived experience may start to believe.

Then examples of language that are associated with stigma are things like crazy, dangerous, unpredictable, incapable, or lazy. Instead of promoting that, we can promote person-centered or recovery-centered language. For instance, instead of referring to someone as a schizophrenic, we put the person first in the language. A person with schizophrenia or diagnosed with schizophrenia. Same with someone who might be using substances. Instead of an addict, we can say a person with a substance use disorder. Also if someone's talking about someone who's 'committed suicide', instead we could say died by suicide. This is language that's really recommended by the directors of the National Institute of Mental Health, the National Institute on Drug Abuse, and is really something that can help people feel seen as a person and feel more empowered in their recovery.

I think one of the take-home messages really is that recovery is possible. In the past, we used to think, okay, if someone's coming in the door for a problem that is X, Y, or Z symptoms of psychosis, that should be the treatment target and that's it. More often, though, if we take a recovery-oriented approach now, we really think about, well, what are the person's goals that make their life worth living for them, and how can we help them achieve those goals? When you ask people who have lived experience with psychosis, what recovery means to them, a group of people have talked about how this might fall into several different domains. Building a self, so reconstructing or strengthening their own identity and empowerment of who they are now, rebuilding their life, the behavioral activities that they may be engaged in, the

social supports that they may have, and then the hope for a better future, thinking about what is possible.

I think Dr. Karmacharya alluded to this about it doesn't have to be all a doom or gloom situation. You can really think about all the amazing things that people do who have lived experience with psychosis. They can become peer specialists, they can become doctors or researchers in the field, they can become people in business or advocates for other people trying to navigate mental health. A lot is possible, and keeping that in mind for ourselves as providers can really translate into the type of hope or the environment that we create when working with clients, who may not always have that hope yet, but could really benefit from it.

Some additional resources for folks who might be interested, there is a psychosis screening toolkit online that has some great free resources, also good examples of language that you or others could use when engaging with clients who might be new to the psychosis care experience. There's also additional training on coordinated specialty care. The Navigate Treatment Manuals that I had mentioned are freely available online, and if people are looking for specific treatments for substance psychosis, there are locators online through SAMHSA or through EpiNet, which is sponsored by the National Institutes of Health. These are examples of those websites there. Thank you so much, and our contact information is listed here. Now we'll move into our audience Q&A.

One of the questions that we had received from the audience earlier was, thinking about how we might be able to convince someone who is experiencing delusions, for instance, or some paranoia, about getting professional help.

Dr. Karmacharya, any thoughts on that?

Dr. Karmacharya: I think part of it is, again, trying to not medicalize things too much, trying to avoid language that includes stigma. If you seem to be having a difficulty, it may be helpful for you to try and talk to someone to just get some idea of what may be helpful, but not bringing up the issue of medication, hospitalization up front, but really trying to say, "It looks like you're struggling, you're having some difficulty with anxiety, you seem much more stressed," trying to get them a foot in the door by, I think, putting it more in this context of them having a struggle and seeking help for it.

Dr. McCarthy: Yes, definitely. I think something that can also be helpful is trying to minimize telling people what to do, and really appealing to people's individual motivations. Trying to find out whatever it is that someone cares about or what is bothering them, if it's not the voices or if it's not their belief system, thinking about are they bothered by the interpersonal conflict that they may be having with others who are seeing what's going on, or difficulty with sleep or school, wherever you can get a foothold to try to get someone into treatment, that can help. Even if there are concerns like substance use on board, for instance, typically we talk about those concerns in the context of whatever it is the person does care about. Really trying to get at the internal motivations for what matters most to the client, and then providing options can really help. If someone's not ready to see a clinician, that could be a great opportunity to see if they might be open to talking to a peer specialist first, someone who's been there, someone who might be similar in age or experience could be helpful.

Another question had come up a bit about what the effects might be if someone is diagnosed with schizophrenia and they're taking medication, and they're still using marijuana every day. Any medication considerations there, Dr. Karmacharya?

Dr. Karmacharya: Again, I think this is where you have this frank conversation with them. You give them the thing. You're saying the medication is doing one thing, the cannabis is doing something opposite, and they're fighting each other. The question of, which one's winning? You may need stronger medications, high doses of medication, if you continue to use marijuana, to still have your symptoms under control. You may be able to really decrease your medication, get on lighter medication if you're not smoking marijuana. Trying to get a sense of, so what are the trade-offs? What are the costs and benefits of each path you're taking? Again, I don't have a whole lot of control over what a patient's going to do, but I think just having that open mind or frank conversation as a way for them to realize on their own what is the right path for them.

Dr. McCarthy: Thank you so much for sharing. To add on to that, I think that we had talked about earlier, even from a diagnostic standpoint, that it can be really useful to see what happens when people take a break from using substances. That's one way that you could frame it. See if folks might be open to doing an experiment. See what it might be like if they're smoking daily to try a day when they're not smoking, or maybe a week, maybe a couple of weeks or a month. You could take a foot-in-the-door approach to help people gather data for themselves about how their symptoms look or how they are feeling with or without that medication without trying to send the message that they can never try it again, if they're going to try it anyway. Really come at it from a curious standpoint can help.

Another question was thinking about thoughts on long-acting injectables, Dr. Karmacharya, what's your experience been with that? How might you include that in the discussion with clients or families?

Dr. Karmacharya: You provide that as one of the options there. Some patients would say, "I really don't like taking pills every day. I cannot remember." People who have a history of non-compliance, but would like to get treatment. Again, there are a number of different ones available, but again, it's a limited number of medications that are options for. Again, the key thing in first episode psychosis is really personalizing the treatment, both in terms of the severity of the illness, the nature of the symptoms that are difficult for them, what their psychosocial situations are, and taking all that into consideration as you pick what is the right medication part of that puzzle. Again, I think it's something that I give to patients as an option, especially for those who would rather just do it once a month and not have to worry about it, once every two months not have to worry about it, and all people who have issues with compliance.

Dr. McCarthy: Great. Thank you. Someone else writes in, what level of care would be most appropriate for a patient presenting with possible psychosis, considering the severity of their symptoms for them to inpatient, outpatient, or intensive outpatient, or partial hospitalization programs? What factors might guide this decision?

I think that here, one thing to keep in mind is that people can experience psychosis symptoms without needing to be in the hospital. Even for people who are

hospitalized, there, it's a crisis stabilization context, and certainly not meant to 'cure or fix' the entire psychosis experience. Much of the work, one way or another, will be done on an outpatient basis. Here, just like with any inpatient hospitalization, we'd really be looking for any signs of imminent harm to themselves or others, certainly suicidality or homicidal ideation, but really also thinking about any significant neglect to oneself. As this relates to specific psychotic symptoms, if someone's hearing command auditory hallucinations, like voices telling them to harm themselves, that might be a time to consider inpatient hospitalization if someone cannot stay safe in that context.

Dr. Karmacharya, any other thoughts that you'd share on the level of care to think about?

Dr. Karmacharya: I agree. I think, safety is the primary reason why we do inpatient hospitalization. These inpatient hospitalizations are not very long, they're pretty short. Also, these can be stressful situations for many patients, too. A lot of patients have very traumatic experiences just being near, because there are other patients who are very sick as well. The primary reason to really get someone inpatient, one is for, if there are any safety concerns, if they're really not willing to seek treatment as an outpatient. I think judging by that and the severity of the symptoms, those are the things we keep in mind when deciding whether to hospitalize someone or not.

Dr. McCarthy: Yes, definitely. Someone else asks, how would cognitive impairment influence treatment approaches primarily targeting positive symptoms or even social skills?

We did touch on the fact that that would be a challenge for some cases, and how we might, as providers, think about how to approach that in treatment. We can think about meeting people where they're at. Some of how we talk to people in session or work with people with home assignments might give us some more information about what people are capable of. For instance, if someone sets a goal and they are able to achieve it, no problem, then they might be capable of doing more advanced or more challenging goals. If they're having difficulty completing a goal that they thought they would be able to complete, that would be a chance to scale back and think about maybe a goal of lower difficulty, or also be really explicit about talking about the challenges of achieving that goal before you send them off to do it. Then coming up with solutions to make it easier to achieve those goals.

From a social skills standpoint, there can be social cognitive difficulties as well. There's something called theory of mind, the ability to perspective take and anticipate what other people might be thinking or feeling, or why they might be doing or not doing a behavior. On average, people who do have psychotic disorders have more difficulty in this area. That can make it a little bit more difficult sometimes, either in the therapeutic setting or certainly with other family members who might think that their loved one may be doing something that they don't understand and realizing that this is part of the cognitive challenge of their presentation and not meant to be anything personal.

I think that's all we have time for questions and the answers. Thank you so much. I'll turn it over to our moderators to close this out.

Operator: Thank you so much for joining us today, Drs. McCarthy and Karmacharya, and particularly for your expertise. I want to thank all of our listeners for participating as well. We'd also like to thank McLean Hospital for making this webinar possible. A recording of the presentation will be emailed to everyone in two weeks time, and the recording will also include the presentation slides. As soon as the webinar has ended today, a short survey will appear on your screen. Please take the survey to provide us with your feedback. We thank you for your attention and hope everyone has a great day. Thank you so much.

[00:57:51] [END OF AUDIO]