First Episode Psychosis Interventions in VA

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Overview

- Overview of FEP programs in the US
- Differences between Veteran and non-Veteran populations
- The promise and challenge of FEP with Veterans
  - Structure of the military
  - Gap in care between military and VA
- Case presentation
- Current FEP efforts at Bedford VAMC and VA
The State of First Episode Psychosis Treatment in the United States
What is the First Episode of Psychosis (FEP)?

- The first period of time an individual has experienced sufficiently severe psychotic symptoms that they qualify for a psychiatric diagnosis.
- Typically adolescent or young adult (e.g., between ages 18-35).
- Some decline in occupational, social, and self-care functioning usually already present.
- FEP as typically used usually excludes mood disorders (e.g., bipolar disorder, major depression), for which psychotic symptoms may be present during a mood episode but not between episodes.
- FEP often eventually evolves into schizophrenia, and may already be schizophrenia by the time the person gets into treatment.
History of FEP Treatment

- Single payer systems may be uniquely situated to do this work
  - Can impose a surveillance system
  - Prescribe provider behavior
- Began in Australia in the 1990s (Edwards & McGorry, 2002).
  - Three key elements: early recognition and assistance, initial assessment and treatment, and promotion of recovery (McGorry, 2002).
- Expanded to England, Denmark, Norway, Canada.
  - More easily implemented and disseminated due to national healthcare systems.
- Significant effectiveness in reducing impairment associated with illness
  - More effective than TAU, including improvements in positive/negative symptoms, quality of life, and social/vocational recovery (e.g., Álvarez-Jiménez et al., 2011; Bird et al., 2010; Correll et al., 2018).
- Team approach is critical—Team includes a project manager and Interventionists providing, typically, individual therapy, family interventions, medication management, and vocational rehabilitation/support—more recently also include case management and peer supports
- Duration of untreated psychosis (DUP) emerged as an important metric from this work. The shorter the DUP, the better the outcomes (e.g., Perkins et al., 2005).
FEP Treatment in the United States

- Large-scale implementation of FEP programs in the US has been slowed due to the manner in which healthcare is delivered in this country (Srihari et al., 2009).
  - True for evidence-based mental health care more broadly (McHugh & Barlow, 2010).
  - Notably low levels of evidence-based mental health care disseminated to clinical practice settings (Stewart & Chambless, 2007).

- Many FEP programs in the US were developed as specialty clinics within academic research programs first; as such, access was limited.
  - First study published on effectiveness of any program was in 2012 (Uzenoff et al., 2012), followed by Srihari et al. (2015).
  - White paper published in 2014 (Heinssen et al., 2014) following 5% set-aside from SAMHSA’s mental health block grant.
RAISE: Recovery After an Initial Schizophrenia Episode

- NIMH randomized controlled trial designed to test the feasibility of implementing FEP interventions in non-specialty settings.
- Compared 34 community mental health settings across 21 different states over two years (N=404).
- Randomized by site to provide treatment as usual or coordinated specialty care (CSC).
- Those that received CSC (Kane et al., 2016):
  - Remained in treatment longer
  - Reported improved quality of life
  - Were more likely to be in school or working
  - Were taking lower doses of antipsychotic medications

![Diagram](image_url)
NAVIGATE

- Designed to be implemented in a **coordinated** manner.
  - Individual resiliency training (IRT; based on CBT-P, psychoeducation, and Illness Management and Recovery [IMR]).
  - Medication management - combination of shared decision making and prescribing algorithms.
  - Family psychoeducation.
  - Supported employment and education.
- Manuals are **FREE** and can be downloaded at: http://navigateconsultants.org/manuals/
- Significant opportunities within VA to approximate this model.
Clinical Considerations when Treating Veterans with Early Psychosis
Engagement

- The duration of untreated psychosis (DUP) is an important metric in the treatment of first-episode psychosis
  - Shorter DUPs are consistently found to have better outcomes (Marshall et al., 2005)
- Studies of first-episode psychosis interventions have shown that merely having a program is insufficient in terms of shortening the DUP (Johannessen et al., 2011)
- Proactive outreach and engagement is an important component of this work
  - Questions of where to best concentrate these efforts are unanswered as few studies have looked at DUP in the United States (none amongst Veteran populations!)
  - Research from overseas populations may not be applicable as European studies tend to find that first contact is typically with primary care, whereas in North America, first contact is typically with emergency services (Anderson et al., 2010)
    - The two studies looking at pathways to care in the United States are consistent with this research (Chien & Compton, 2008; Compton et al., 2006)
Engagement

- It is critical to engage these Veterans with whatever services they self-identify as most important.
  - Often, these are developmentally-appropriate and include matters such as employment or romantic relationships
  - If the Veteran is on an inpatient unit, it may be helpful to point out that these services are designed in order to support community functioning and reduce inpatient hospitalizations
- Veterans may or may not be engaged with their families. If family members are present and supportive, they may be helpful in engaging Veterans in treatment
Age of Onset of Psychosis

- Three studies have found that Veterans retrospectively self-report a later age of onset than non-Veterans
  - Two studies have reported a later age of onset amongst Veterans with a psychotic diagnosis than non-Veterans
    - 27.61 yrs for Veterans compared to 24.96 yrs for non-Veterans (Thorp et al., 2012)
    - 27.57 yrs for Veterans compared to 24.37 yrs for non-Veterans (Harvey et al., 2000)
  - A third also reported a later age of onset for Veterans, but did not provide any specific statistics (Firmin et al., 2016)
- Veterans with a psychotic diagnosis in the 18-24 year range do not seem to be engaging in VA services
- Reasons:
  - Must reach a minimum level of functioning to enlist in the military
  - Desire to hide symptoms while in the military in order to remain in the military
PTSD

- Rates of PTSD vary depending on service era (National Center for PTSD)
  - OEF/OIF/OND- about 11-20% meet criteria for PTSD in a given year
- Female Veterans (13.4%) are more likely to have PTSD than female civilians (8.0%), male Veterans (7.7%), or male civilians (3.4%) (Lehavot et al., 2018)
  - Although male Veterans have the longest delay in seeking treatment
- Veterans with schizophrenia or schizoaffective disorder have high prevalence rates of PTSD, with one study finding that 47% meeting criteria for PTSD, although only 14% of those who screened positive had a diagnosis of PTSD in their chart (Calhoun et al., 2007)
The Trauma of the First Episode

- There is evidence that the experience of psychotic symptoms are, in and of themselves traumatizing. Further, the treatment of these symptoms are sometimes considered to be more traumatizing than the symptoms themselves (Mueser & Rosenberg, 2003)
  - Given that a common symptom of PTSD is avoidance, the fact that individuals experiencing psychosis sometimes find the treatment traumatizing, this may have implications for treatment adherence (Mueser & Rosenberg, 2003)
  - Studies examining the traumatic experience of first episode psychosis indicate that symptoms of trauma in response to the first episode are widespread (Tarrier et al., 2007)

- Treatments aimed and working with this population need to include space to help individuals process this experience in a way that will allow for them to continue engaging in treatment
  - The NAVIGATE model emphasizes both processing the psychotic experience, planning for relapse in a proactive way, and shared decision making as tools to help increase engagement and process these traumatic experiences
Military Sexual Trauma (MST)

- MST – Psychological trauma that resulted from assault of a sexual nature, battery of a sexual nature, or sexual harassment that occurred while the Veteran was on active duty, active duty for training, or inactive duty training.

- National Center for PTSD: Among Veterans who use VA health care:
  - 23 out of 100 women reported sexual assault while in the military
  - 55 out of 100 women and 38 out of 100 men have experience sexual harassment while in the military
  - The overall incidence rates of MST are higher for men than women because there are more men enrolled in the military, although the relative rates of MST are higher for women than men
Suicide

- From 2005 to 2016, adult suicide rates increased for both Veterans (by 25.9%) and non-Veterans (by 20.6%)
  - The suicide rate for Veterans ages 18-34 increased substantially from 40.4 deaths/100,000 in 2015 to 45 deaths/100,000 in 2016
- In 2016, the suicide rate for Veterans remains 1.5 x’s greater than non-Veterans after adjusting for age and gender.
- Between 2005 and 2016, after adjusting for age differences, Veterans in VHA care also show an increase in the overall rate of suicide; however, this rate increase was less substantial compared to Veterans who were not engaged with VHA care

Suicide/Death Ideation Amongst Veterans with SMI

- Suicide ideation- thought of wanting to kill oneself
- Death ideation- thoughts of death or wanting to die without explicit thoughts of wanting to commit suicide.
- Participants – (N=516) adults with SMI (schizophrenia, schizoaffective disorder, bipolar disorder, MDD, psychotic disorders) recruited from community MH programs or VA
- Veterans reported both death and suicide ideation more than twice as often as non-Veterans
  - 14.3% of Veterans and 6.7% of non-Veterans reported suicide ideation
  - 38.8% of Veterans and 18.0% of non-Veterans reported death ideation
- Depressive and psychotic symptoms were predictors of death ideation and depressive symptoms and hostility were predictors of suicide ideation

Jahn et al., 2018
Family Engagement

- NONE of the Veterans in the STEER program have been willing to engage in the family psychoeducation arm of the intervention.
  - This is consistent with the general trend for family members of Veterans to report wanting treatment, but not receiving it (Sherman et al., 2005)

- Unique aspects of FEP Veteran care that make family engagement difficult:
  - Veterans have a period of independence and separation from their families
  - Some Veterans join the military to escape poor family environments
  - It’s not “normative” for Veterans to engage their family members “I don’t want to burden them”

- However- Veterans with SMI want their families involved in their care. One study found that 78% of Veterans with an SMI diagnosis reported wanting family members involved (Cohen et al., 2013).

- Shared Decision Making protocols have been found to increase contact between family members and the clinicians (although only with the clinician delivering the intervention (Dixon et al., 2014)).
The Promise and Challenge of FEP in VA
Structure of the Military
Shortened Duration of Untreated Psychosis

- Hann, Caporaso, Loeffler, Cuellar, Herrington, Marrone, & Yoon, 2018
- Naval Medical Center San Diego Psychiatric Transition Program - only military first episode psychosis treatment program
- Retrospective chart review
- N = 69 Age – 18-41 yrs
- DUP (detection of first psychotic symptoms to administration of PRN antipsychotics)
  - Mean DUP 21.15 days
  - Median DUP 2 days
  - Modal DUP 0-2 days (!!!)
Service members who are deemed to be unfit for duty are sent to a Medical Evaluation Board for review.

Report is then forwarded to the Physical Evaluation Board who determines if the service member can continue in the military or if they are to be discharged.

The diagnosis of a psychotic disorder or the prescription of an antipsychotic automatically triggers a Med Board.
Gap Between Military and VA
Benefits of the VA system

- Large, centralized medical system with high potential for coordinated care—even with medical care
- Promotion of telehealth and telehealth resources – including resources for Veterans
  - The use of the internet or phone is acceptable to nearly half of OEF/OIF/OND Veterans with younger Veterans being more open to telehealth services (National Academy of Sciences, 2018)
- System of reimbursement will cover vocational services!
- VA has systematically implemented an evidence based practice training program which has greatly increased availability of MH EBP’s throughout the VA system (Karlin & Cross, 2014)
  - Although SMI specific interventions are lacking
VA Utilization rates of OEF/OIF/OND Veterans

As of 2015, of the 1,965,534 OEF/OIF/OND Veterans, 1,218,857 (62%) have obtained any VA healthcare since 2002.

Quarter 3, FY15

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<th>Number with a MH Dx</th>
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<tr>
<td>PTSD</td>
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<td>Depressive Disorders</td>
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<td>Neurotic Disorders</td>
<td>309,232</td>
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<td>Affective Psychosis</td>
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*Rates are cumulative

Epidemiology Program, US Department of Veterans Affairs, 2017
Barriers to Engaging in VA Services for OEF/OIF/OND Veterans

- Approximately 30-40% of Veterans report that they don’t know how to enroll, don’t think they are eligible for services, and are generally not aware of MH care benefits (National Academy of Sciences, 2018)
- When using MH screeners or Veteran reports of diagnoses, approximately ½ of OEF/OIF/OND Veterans who might need MH treatment are not receiving it (National Academy of Sciences, 2018)
- As noted previously, OEF/OIF/OND Veterans receiving disability may be particularly susceptible to internalized stigma (Harris et al., 2015)
Case Presentation
Two pathways to care-

Onset of symptoms occurred during the military and was discharged to VA care

- 24 y/o, single, Caucasian male
- Symptom onset in April 2018. Diagnosis of schizoaffective disorder. Hospitalized and discharged from the military shortly after
- Currently living at home with parents. Symptoms are generally well-controlled, although is struggling with significant depression and feelings of lack of purpose
- Engaged with STEER in Aug of 2018- participated in individual therapy, medication management, and vocational rehabilitation
- Is working full-time but dislikes his job. Recently met with someone from voc rehab to good effect

Onset of symptoms occurred after the military and began engaging VA care at onset

- 27 y/o married, Caucasian male
- Navy Veteran
- Symptom onset began in fall of 2018 and consisted of ideas of reference, paranoia, and sub-threshold delusions. Symptoms are in partial remission
- Is currently unemployed after losing a job, which was a probable consequence of psychotic symptoms, although this is not entirely clear
- Wife and her family encouraged that he engage in treatment and came to VA in Feb 2018.
- Has met with an individual therapist and had a joint meeting with his wife. Refused voc rehab and medication management
- Currently planning to move to Ireland with his wife, who is from there. Treatment has largely focused on relapse prevention
Current FEP Efforts at VA
Nationwide Efforts

- A great deal of interest in implementing FEP interventions in VA, but currently there is no guidance from VACO regarding implementation of programming
- VA is developing national guidance on treatment of recent episode psychosis in VA—Dan Bradford, MD overseeing effort
- Recent onset workgroup with representatives from VISNs 1, 6, 21, 22 meeting monthly
- Proposed hub and spoke model—FEP case manager hooking consumers up to CSC services
- Working to overcome barriers to recent onset care in VA
  - Culture of treating more long-term patients—not necessarily expecting recovery
  - Lack of training in interventions specific to psychosis
  - How to define recent onset when there may be a lag of entry into treatment of years
  - National guidance only now being developed—community care more advanced in this regard
Veterans with a Psychotic-Spectrum Diagnosis in VISN 1

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<th>Other NE VAMC’s</th>
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<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
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<tr>
<td>Total # of Vets</td>
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<tr>
<td>Age 18-24</td>
<td>14</td>
<td>0.03%</td>
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<tr>
<td>Age 25-29</td>
<td>39</td>
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<tr>
<td>Age 30-35</td>
<td>65</td>
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STEER- Specialized Team for Early Engagement and Recovery

- First VA FEP program!
  - Other VA’s are working to develop these models and are in various stages of development
- NAVIGATE model of treatment –
  - Team provides individual therapy, shared decision making, and family interventions
  - Partner with medication providers and vocational services at Bedford
STEER- Specialized Team for Early Engagement and Recovery

- Initial phase- 2015-2018
  - Attempt to develop a NAVIGATE consistent treatment team model by identifying staff members who could fulfil each branch, including psychiatry, vocational rehabilitation, & psychology
  - Engagement of any Veteran under the age of 35, regardless of length of illness as an attempt to develop referral sources

- Current phase- Spring 2018- Present
  - Focus more on coordinating with other pogroms that can provide staffing and developing a collaborative model
  - Emphasis on Veterans within the first 5 years. Veterans who have shown symptoms for more than 5 years are referred to CBT for psychosis
STEER- Specialized Team for Early Engagement and Recovery

- Future Directions
  - Partnership with other VA’s in the VISN to cover needed services?
  - Develop better connections with Department of Defense to facilitate smoother transition of care
    - Utilize telehealth services to develop a relationship with the service member pre-discharge
  - Develop better relationships with non-VA Veteran care providers
THANK YOU!