Adverse Childhood Experiences, Serious Mental Illness/Substance Use Disorders and Tailoring First Episode Psychosis (FEP) Programs to Serve Women

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Disclaimer

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Thank You, Phil!

- Data presented from McLean OnTrack courtesy of Phillip Benjamin Cawkwell, MD

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Objectives

- Explore treatment environments for women with co-occurring first episode psychoses (FEP), substance use disorder (SUD), and histories of trauma.
- Identify knowledge gaps and areas for improvement.
- Discuss educational needs of the workforce caring for this vulnerable population.

Presentation Outline

- **Part 1:** Discuss data from McLean OnTrack Outpatient Program and care environment with case study.
- **Part 2:** Briefly explore psychotic disorders inpatient treatment environment and community links with case studies.
- **Part 3:** Identify educational needs of the workforce and specific areas for improvement.

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Outpatient FEP care environments: Experiences from McLean OnTrack

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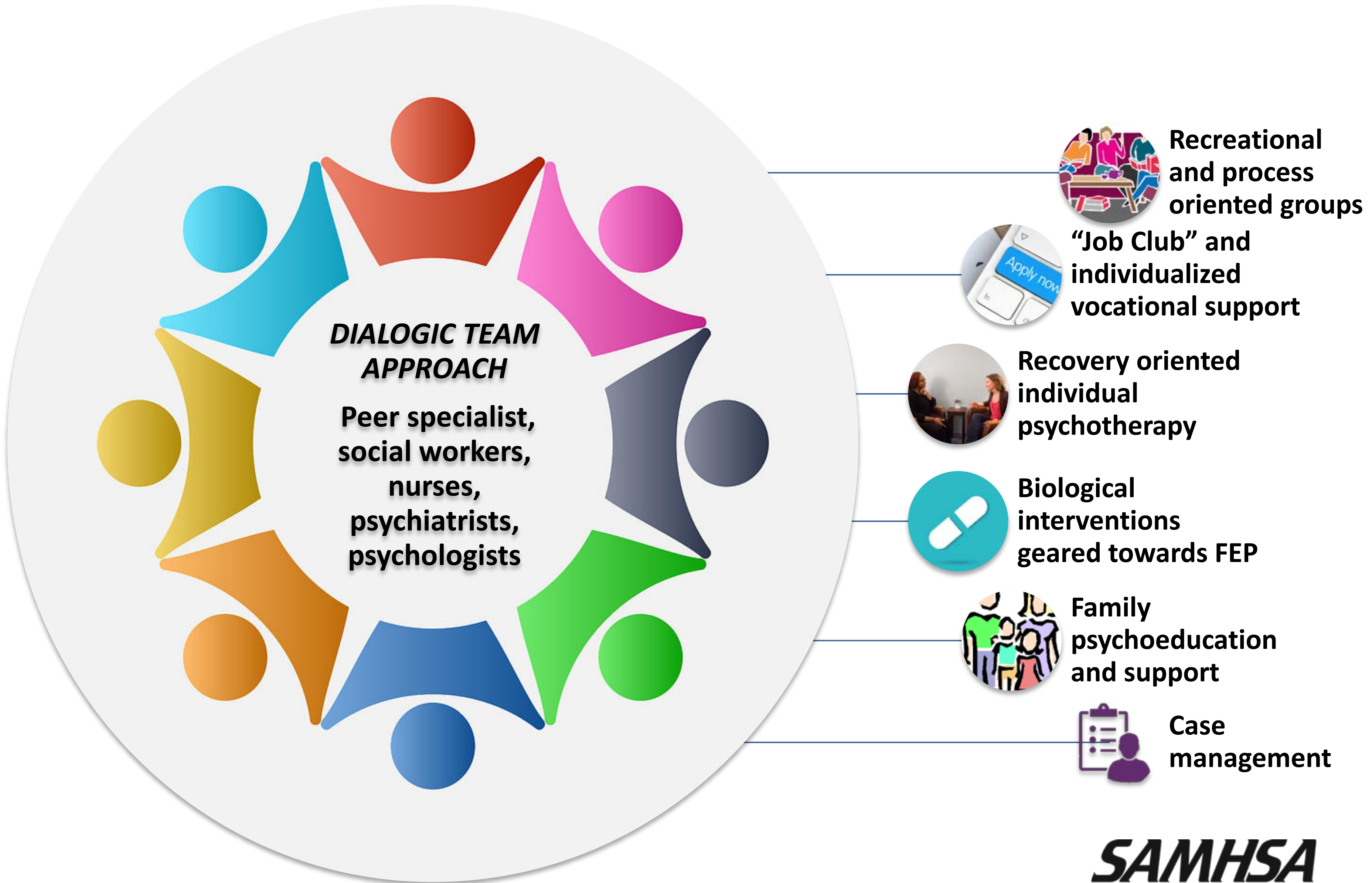
What is McLean OnTrack?

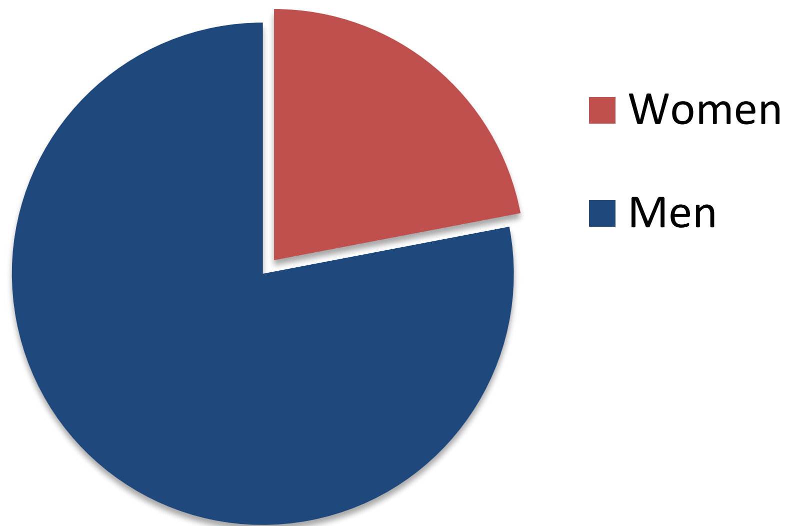
- Outpatient FEP program
  - 2-5 year timeframe
  - Psychosis onset in past year
- Chronicity is not an option!
- Transdiagnostic
- Integrated wellness approach
- Flexible approaches to care/engagement
- Light touch to psychiatric medications
- Functional recovery over symptom recovery

Clinical structure of McLean OnTrack



Many more men treated than women . . .

N=49 women



- Why the disproportion?
- Are there factors influencing pathways to care?
- Is this common?
- How and why is this problematic?

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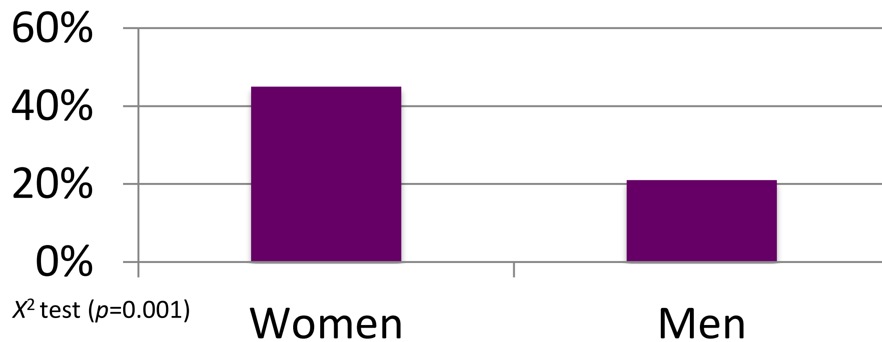
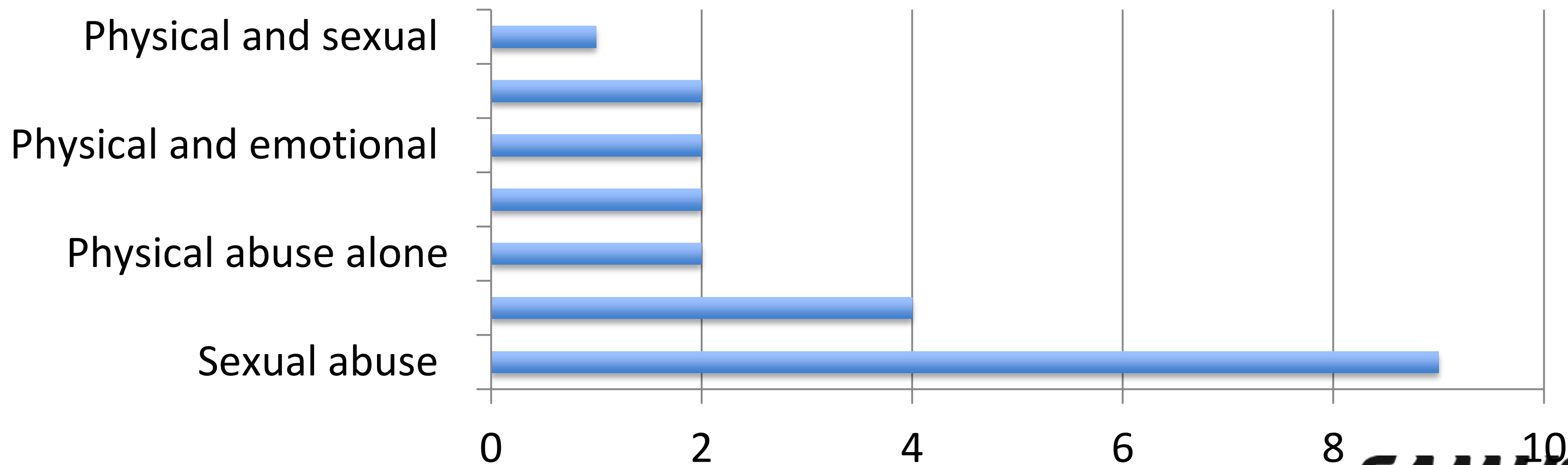
Gender differences of trauma in McLean OnTrack



X^2 test (p=0.001)

- Significantly more women than men endorse trauma, and of those women who endorse trauma, the most common type is sexual abuse.



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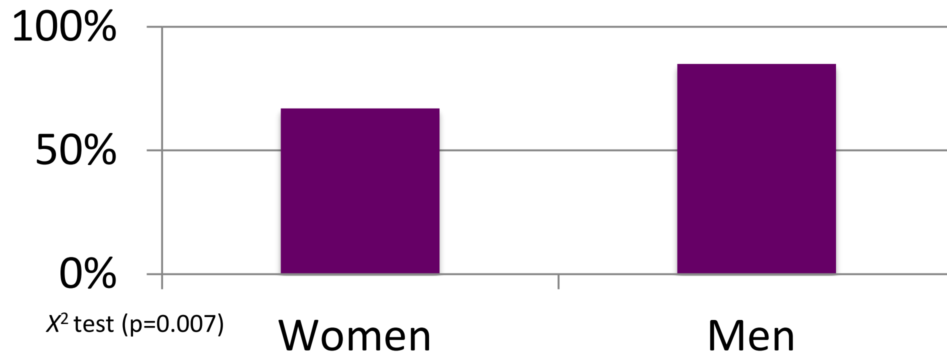
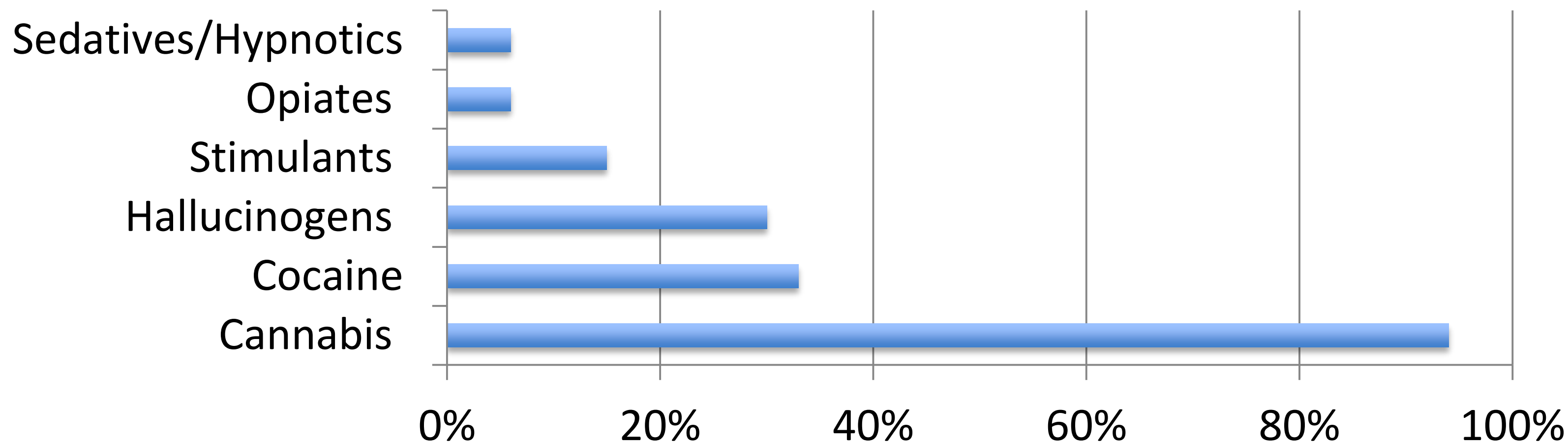
Gender differences of substance abuse in McLean OnTrack



- Significantly more men than women abuse substances. Of those women who abuse substances, cannabis is the most common.



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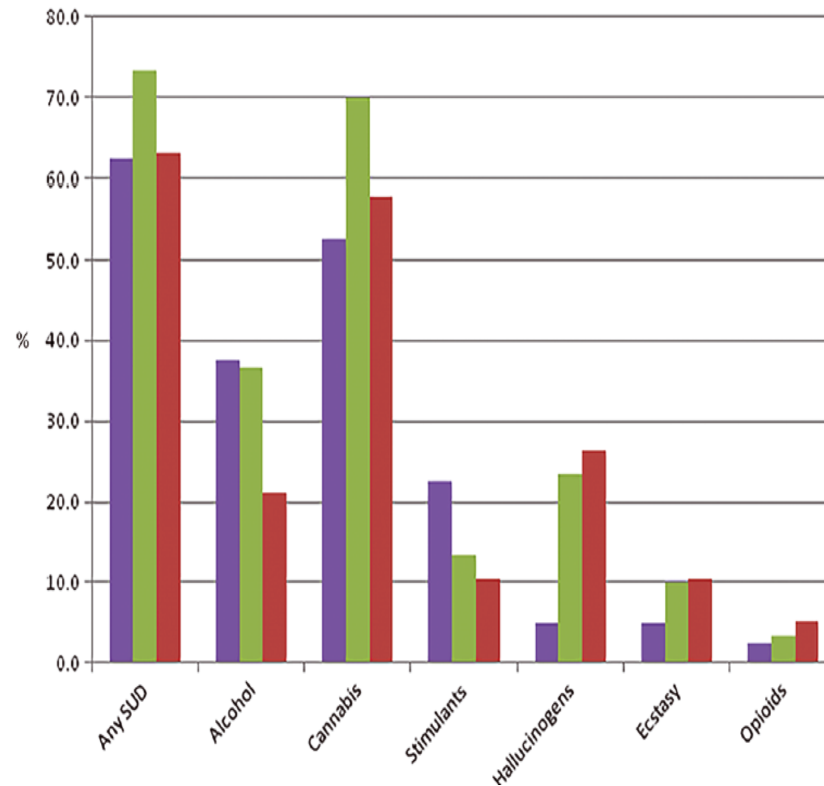
Cannabis

FIGURE 2. Prevalence of pre-morbid substance use disorders (SUD) among all enrolled McLean OnTrack patients. SUDs are highly prevalent among our first-episode patients, regardless of psychosis category. Cannabis use disorders are the most common. (■) Affective, (■) Non-affective, (■) Psychosis NOS.



- Cannabis is problematic for both males and females and is present across psychosis categories

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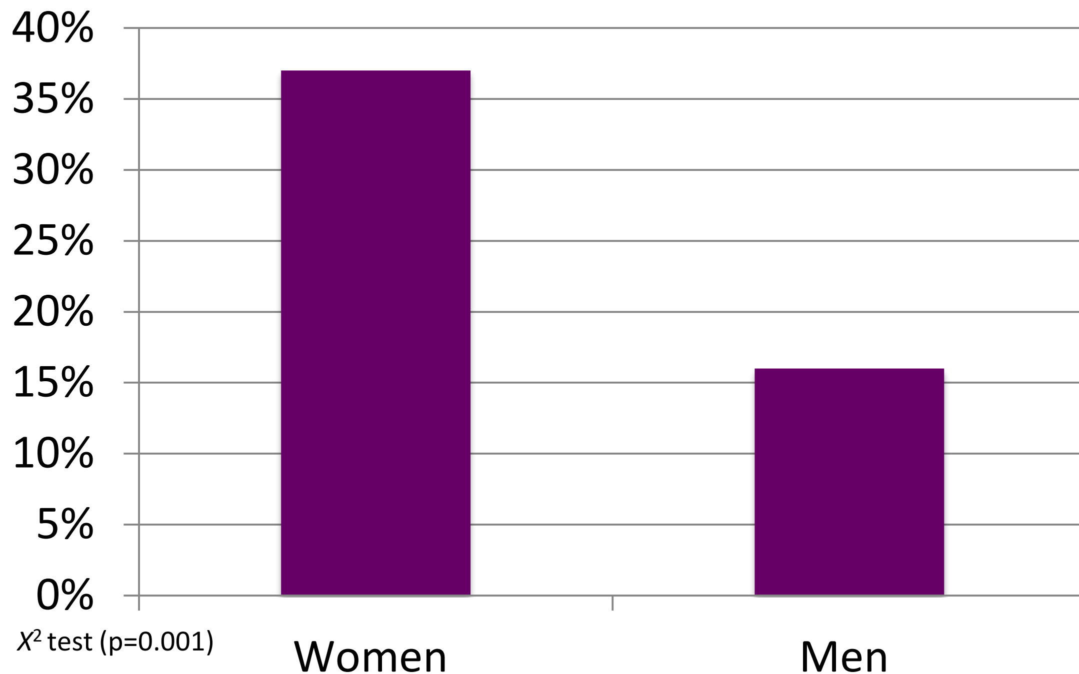
Gender differences of trauma + substance abuse . . .



- Significantly more women have both trauma and substance abuse histories when compared to males.

- Women with T+SA in McLean OnTrack *may* be more likely to have affective psychosis (approaching statistical significance p=0.079)
  - Limits access to traditional FEP resources?
  - Treatment programs are still structured to accommodate more typical FEP.

Diagnostic differences?

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No differences in regard to . . .

- No differences between women with trauma + substance abuse compared to the rest of the McLean OnTrack group in regard to . . .
  - Insight into illness
  - Referral source
    - Largely inpatient units
  - Age
  - Number of hospitalizations at baseline

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*Real World Outcomes?

- Women without trauma and substance abuse are more likely to be college graduates and have attained their graduate degrees.

50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

College graduate
Graduate degree

T+SA
No T+SA

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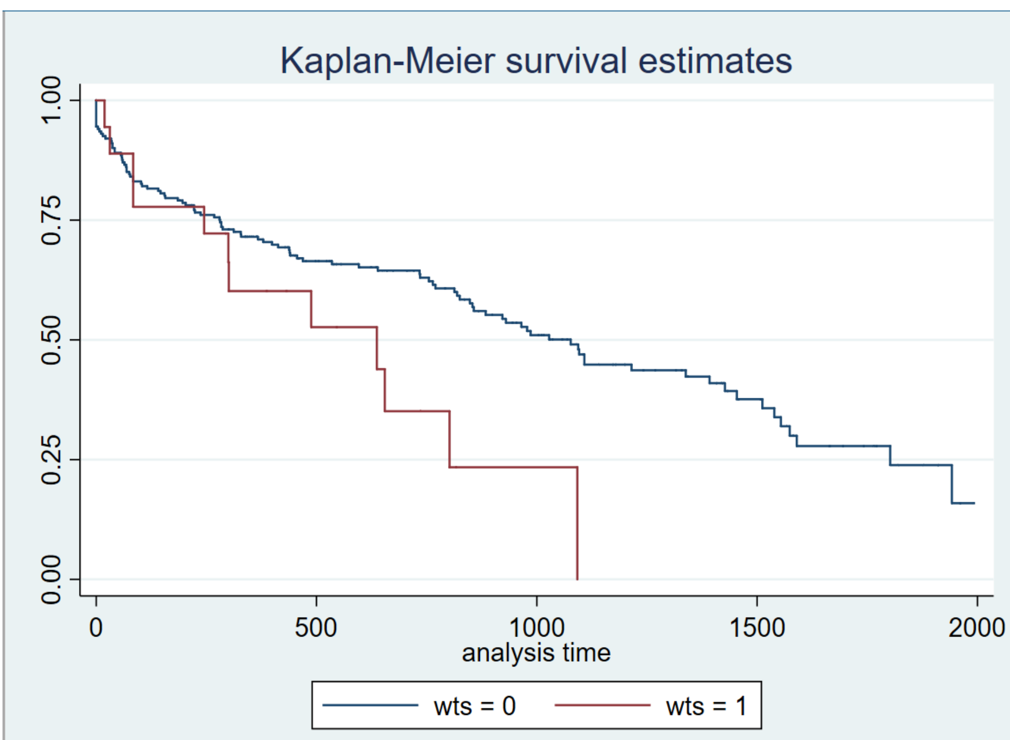
Treatment Outcomes?



RED= women with T+SA BLUE= OnTrack group

(p< .03)

- Women with trauma and substance abuse histories are significantly more likely to disengage from treatment earlier than the rest of the individuals in the McLean OnTrack program.

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Addressing the issue in McLean OnTrack

- Clinical training in DBT
- Rolling with resistance
- Non expert stance
- Women’s group (new)
- Flexing age range (>/= 35 years)
- Finnish Open Dialogue model
  - Humanistic approach
  - Tolerating uncertainty
  - Decrease isolation

Case example

Interrupting the cycle

Areas for improvement . . .

- Increase support groups geared towards women
  - Women and pregnancy
  - Substance abuse
  - DBT
- Aesthetics of OnTrack space
- Better public awareness
- Better recruitment
- Female peer specialists

Inpatient care environments: McLean psychotic disorders inpatient unit

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Care Environment

- Two 21 bed adult inpatient units
- **Men and women**
  - Many are referred from community emergency rooms experiencing acute psychotic episodes.
  - Commonly struggling with access/adherence to treatment in community
- **Psychotic disorders**
  - First episode psychosis
  - Bipolar disorder, schizophrenia spectrum disorders
  - Substance induced psychosis
    - Cannabis use

Care Environment

- Rooms
  - Single and double occupancy
- Wings
  - Higher acuity wing
  - Not separated by gender
- Communal areas
- Male and female staff

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Care Environment

- Open Dialogue model for daily rounds
  - Active involvement of patient
  - Patient centered language
- Sensory Interventions
- Substance use consults
  - Motivational interviewing
- **Crisis Prevention Planning**
  - Linking back to community services such as DMH case management, co-occurring treatment programs, partial hospitalization, day programs, club houses and PACTs
  - Assist with transition out of the hospital and prevent readmission

McLean Referrals, Aftercare

- PACT
- OnTrack
- Hill Center
  - Residential program (2 weeks) for women with trauma histories and concurrent mood disorders
- Appleton
  - Residential program (3 months) for adults with bipolar disorder or schizophrenia as primary diagnosis and co-existing conditions such a substance use disorder

Gaps:

- **Socioeconomic**
- Lack of preventive services in community
- No prior knowledge of prodromal symptoms

Trauma Informed

Re-traumatization		**Trauma Informed**
• Treated as number	⇨	• Individualized care - gender specific
• Focus on labels	⇨	• Person centered language
• Lack of choice, non-collaborative approach	⇨	• Involvement in treatment planning, offer choices when possible
• No opportunity for feedback, not feeling heard	⇨	• Rounds structure, dialogic approach

(Institute on Trauma and Trauma-Informed Care, 2015)

Case Study

- Single black female, late teens (infant placed with relatives)
- **Trauma history –** IPV (boyfriend, father of child), possible ACEs (abuse)
- **Substance use –** Cannabis
- **Admitting symptoms –** paranoid delusions, auditory hallucinations, assaultive (kicking, punching, spitting) behaviors
- **Approach –** Female staff, conscious of trauma history, focus on person as separate from illness. Supported with boundaries with boyfriend, created safe space.
- **Outcomes –** She was engaged in treatment decisions. Family involved in treatment and aftercare plan.

Areas for Improvement

- Unit design
  - Women on unit can report
    - Fear from male patients
    - Discomfort with male staff doing safety checks
    - Discomfort with using shared bathrooms

- Additional training in trauma informed education, ACEs and specific developmental trajectories with women.

Workforce Development

Addressing trauma in the care environment

- Importance of creating supportive and validating environments for women that acknowledge a relational context (Salter & Brechenridge, 2013).

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Understanding vulnerabilities

- Women with trauma histories struggle with fragile treatment alliances complicated by stressful life events, substance use and emotional reactivity (Najavits, 2013).

Gender differences during treatment

- Women are more likely to internalize problems, especially within the family system. Men are more likely to display aggression (Caton, Xie, Drake & McHugo, 2014).

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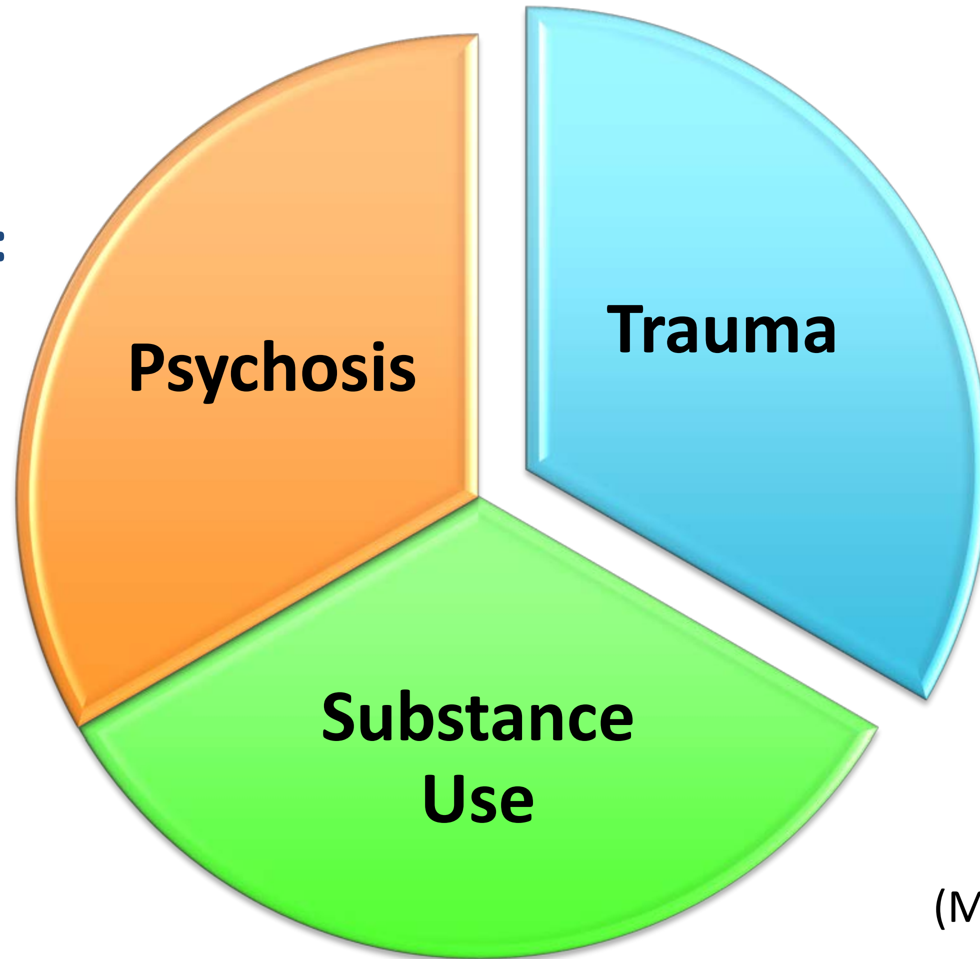
Cycles of trauma, psychosis, substance use

Increased vulnerability to:

- Future trauma
- Poor treatment adherence
- Poor social support
- Substance relapse



Developmental functioning:

- Emotional sensitivity
- Family problems
- Impaired cognition
- Less education

(Mayo et al., 2017)

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Trauma-Informed Approach

Organizational level	Clinical level
Communicating the message	Non-authoritative, non-expert approaches
Training clinical and non-clinical staff	Screening for trauma
Creating a safe environment	Communication with referral sources
Preventing secondary trauma	Training staff in trauma-specific approaches
Prioritizing a trauma-informed workforce	Care communities
Including patients in decision-making	(Menschner & Maul, 2016)

Same questions ?????????

- Why the disproportion?
- Are there factors influencing pathways to care?
- Is this common?
- How and why is this problematic?

References

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