



EASA Center for Excellence

Early Psychosis Intervention:

What is it? How is it different? Why does it matter?





EASA Center for Excellence

Who We Are and How We Got Here



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Early Assessment and Support Alliance (EASA)



- 2001 *managed mental healthcare initiative* in 5 counties (Mid-Valley Behavioral Care Network)
 - Roots: Early Psychosis Prevention and Intervention Center (EPPIC) in Australia
- 2007 legislature began *statewide* effort; Oregon Health Authority position created
 - Subsidy to ensure access regardless of funding
- *EASA Center for Excellence* partners to provide coordination, training, consultation, coaching, practice guideline and fidelity review development, planning and program development support



Early Psychosis Timeline

| EPPIC, AU | Int'l: TIPS/OPUS, Commonwealth dissemination NAPLS → | PIER | EASA | CA Prop 63/ IRIS (UK) | OR statewide EDIPPP | RAISE began | 5% Set-Aside |
|-----------|--|------|------|-----------------------|---------------------|-------------|--------------|
| 1988 | 1989 | 2000 | 2000 | 2000 | 2000 | 2000 | 2000 |
| | | 0 | 0 | 0 | 0 | 1 | 1 |
| | 0 | 0 | 1 | 4 | 7 | 0 | 4 |



What is EASA?



“Uniting the voices and strengths of young adults and their allies to create a thriving community and a revolution of hope!”
– Young Adult Leadership Council

Why It Matters: It is Predictable and Affects a Lot of People

- Approx. 100,000 new adolescents & young adults develop first episode psychosis each year in the U.S.
- Approximately 3% will experience psychosis at some point
 - Multiple causes
 - 274 NEW adolescents and young adults per day
 - Utah: 1-3 new young people every day
- .7/100 will develop schizophrenia
- Time of onset- same as time when least likely to receive healthcare.



“It was like we had fallen off a ship and were drowning, and someone threw us a life preserver.”



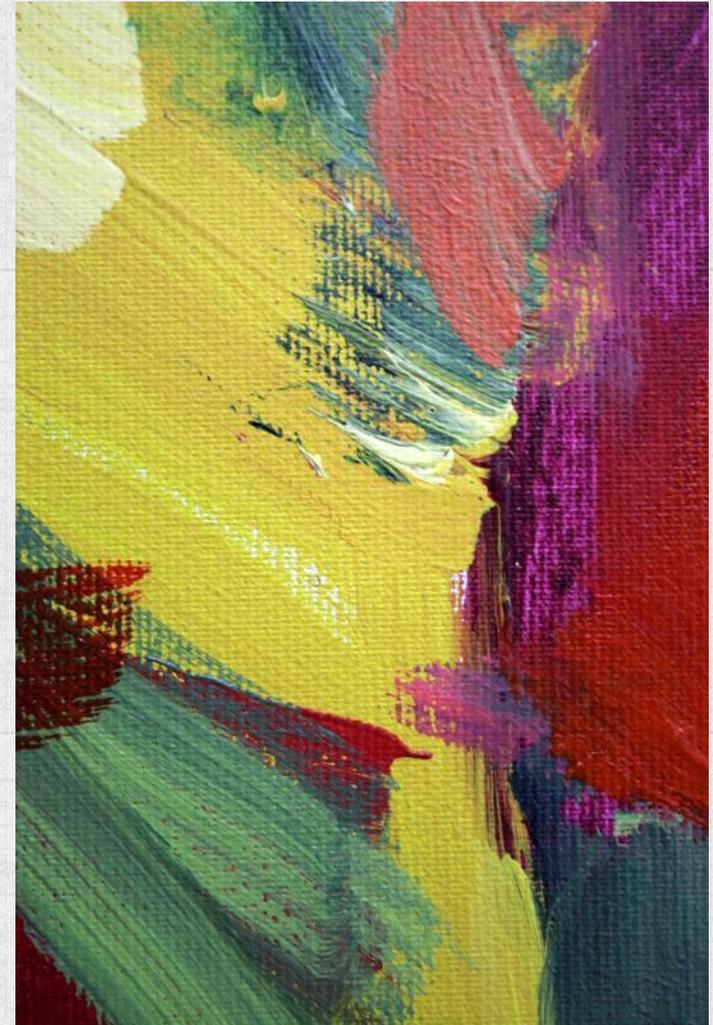
Acute and Life-Threatening



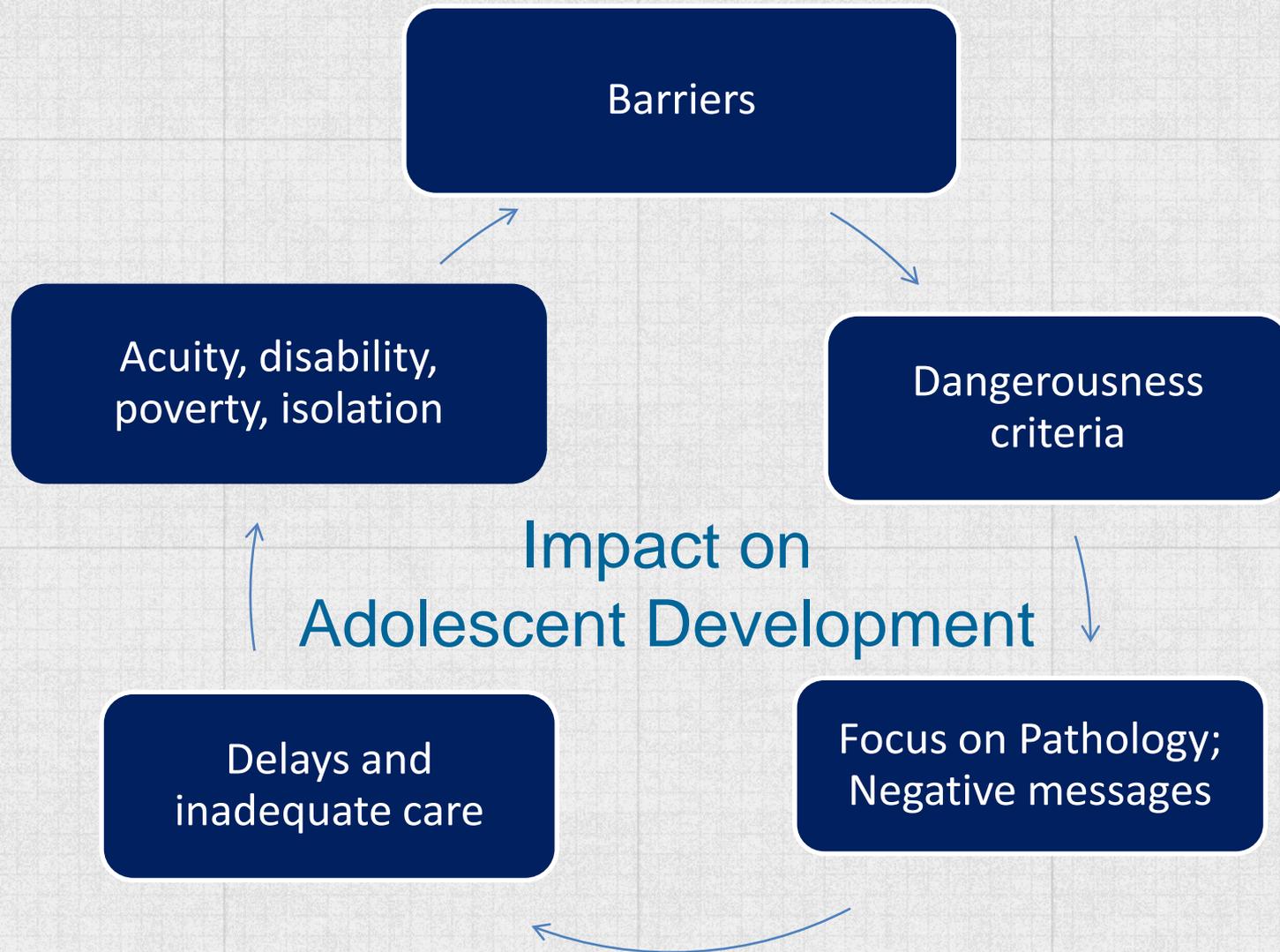
ACUTE PSYCHOSIS

Loss of ability to discern what is real from what is not

- Hallucinations
- Delusions
- Thought disorder



The Journey of Psychosis without Early Intervention



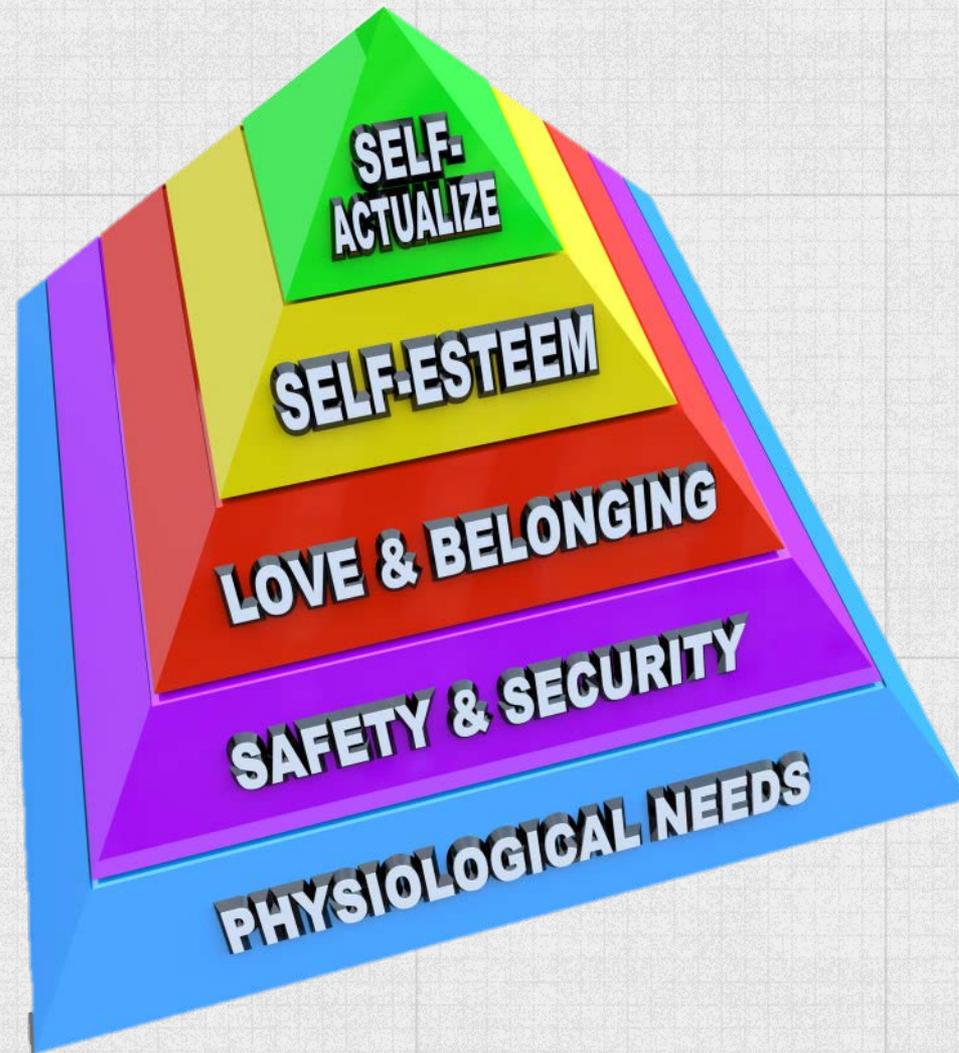


Why It Matters: Onset During Key Developmental Years

- Individuation and independence
 - building independent living skills
 - taking on adult roles & responsibilities
 - forming reciprocal adult relationships
 - includes romantic/sexual relationships, dating
- Identity development
 - “who I am, who I want to be”
- Vocational development
 - Finishing school, beginning career trajectory
 - Often a time of big dreams/ambitions



Impacts All Areas



Schizophrenia: Huge Costs, Terrible Results

- **Cost to society** \$62.7 billion dollars in 2002 (Wu, 2007)
- **Unemployment** Employment less than 20% (Salkever et al. 2007)
- **Disability and early mortality** *8th leading cause of disability-adjusted life years worldwide ages group 15-44. Life expectancy is reduced by 10 years* (World Health Organization, 2001).
- **Victimization and suicide**
 - *Twice as likely to be victims of violence* (Teplin, McClelland, Abram & Weiner, 2005).
 - 20% of all suicides under 35 (Appleby, Cooper, Amos, & Faragher, 1999), *most after onset of illness* (Palmer, Pankratz, & Bostwick, 2005).
- **Homelessness:** one study found that one in five people with schizophrenia had no fixed address (Folsom 2005).
- **Lack of access to effective care.** (Drake & Essock, 2009).



“Prodrome” Research

- Extensive research showing gradual onset (Cornblatt et al, 2003; Glahn et al 2005 among others)
 - Working memory, processing speed, and other neurocognitive domains
 - Affective symptoms and social withdrawal
 - Perceptual distortions and auditory hallucinations
 - Bizarre beliefs without the conviction
 - Often distressing/recognize something is wrong
- Psychosocial treatment highly effective



Why it Matters: Delays in Treatment

- Average Duration of Untreated Psychosis (DUP) in the U.S. is more than 2 years (Marshall et al 2005)
- Delay associated with
 - More severe symptoms (Boonstra et al., 2012; Hill et al., 2012)
 - Decreased rates of remission (Marshall et al., 2005)
 - Decreased social function and quality of life (Hill et al., 2012; Marshall et al. 2005)



Why it Matters?

- Real lives



Early Intervention Works!



- Improved functioning in work and school
- Improved quality of life
- Decreased need for medications
- Decrease relapse & hospital readmissions
- Increased treatment engagement
- Decreased trauma

(Bird et al., 2010; Nordentoft et al., 2014; Norman et al., 2011; Penn et al., 2005)



Early Intervention Works! Long-Term Benefits

- Research still evolving, but existing studies suggest shorter-term gains maintained:
 - Over 5 years when sustained lower-level supports provided past intensive EIP services (Norman et al., 2011)
 - In the domain of independent living (Nordentoft et al., 2014)
 - When early intervention successfully reduces DUP (Cechnicki et al., 2014)



Early Intervention Works! Cost Effectiveness

- Patients involved in early intervention programs vs. treatment as usual over 8 years (Mihalopoulos et al., 2009)
 - Decrease in annual treatment cost per individual (\$3,445 vs. \$9,503)
- Additional economic impact:
 - Savings in societal costs and costs to families
 - Lifetime earnings; preventing disability



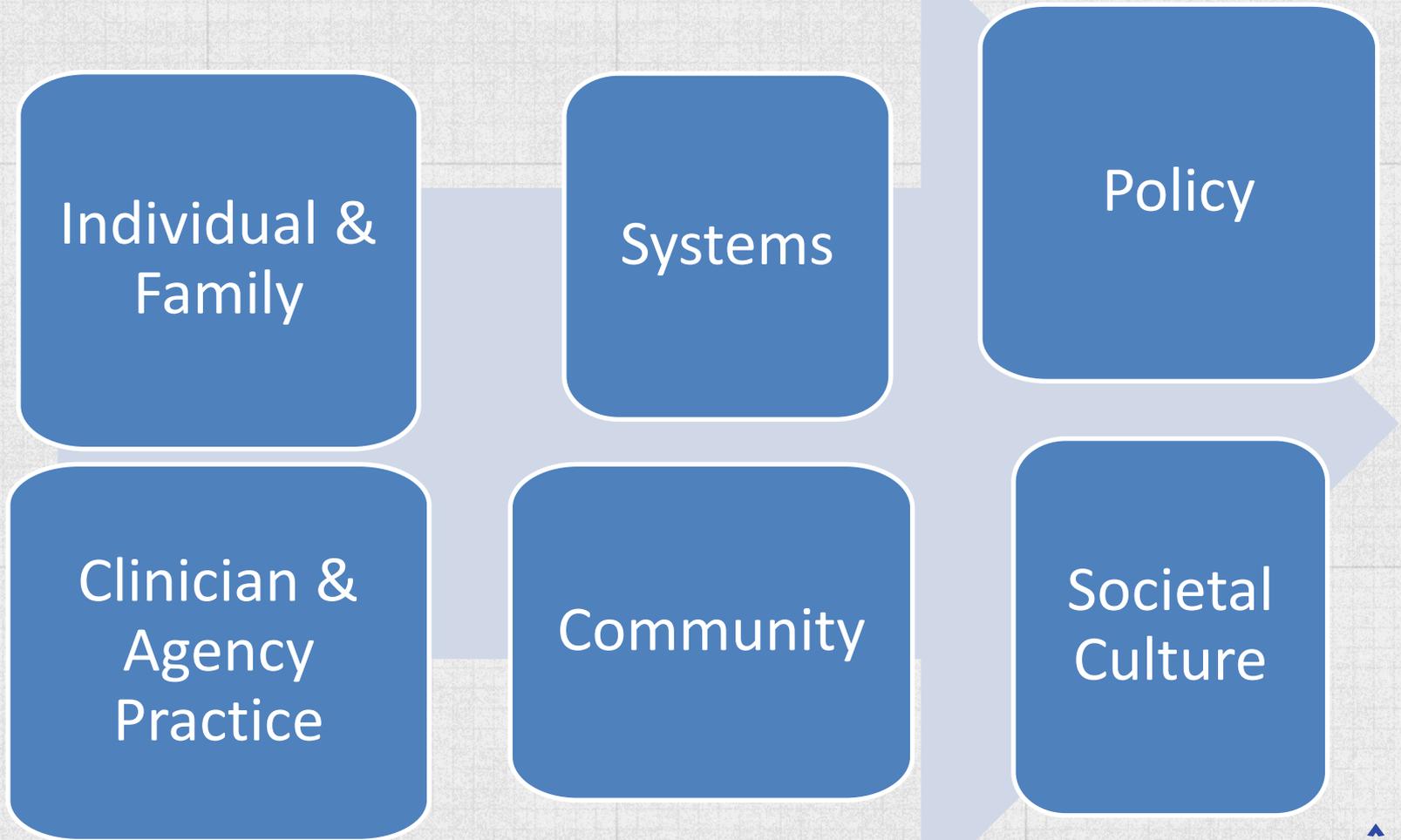
How Early Psychosis Intervention is Different: Cycle of Recovery & Wellness



HOW IT'S DIFFERENT



CHANGE EFFORT



System Change

Without

- Funding is driver
- Access limits



With

- Vision and values are driver
- Problem solving and leadership
- System development
- Access



How It's Different: Community-Focused

Without

- Don't recognize symptoms
- Don't know where to go



With

- Systematic and persistent community education



Proactive

AVAILABLE
ACCESSIBLE
AFFORDABLE

Without EPI



With EPI

- Waiting lists
- Must:
 - seek services
 - show up
 - be motivated
 - meet requirements

- Rapid response
- Anyone can refer
- Active outreach to build trust



How It's Different: Teens/Young Adults



Without EPI:

- Adult/child systems separate
- settings scary or intimidating, not youth-friendly

With EPI:

- One team
- Youth-friendly



Empowerment Focus

Without EPI

- Based on diagnosis, pathology
- Not accepting diagnosis considered “lack of insight”
- Goal: stabilization
- Stigma comes from ignorance and stereotyping. Once you realize stigma is just an ignorant state it allows you to look past

With EPI

- Focus on functioning and person’s goals
- Address stigma
- Goal: developmental progress



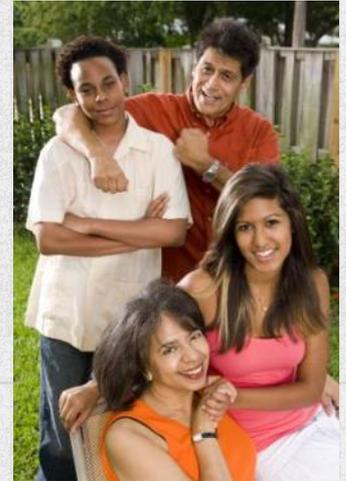
“Stigma comes from ignorance and stereotyping. Once you realize stigma is just an ignorant state it allows you to look past and say hey, this is interesting.”



“Going through something traumatic like this makes you stronger; it’s not a sign of weakness.”

-EASA Young Adult Leadership Council

Family-Centered



Without EPI

- Families often overwhelmed, traumatized, under-informed, isolated and blamed
- Treatment conceptualized as individual

With EPI

- Families:
 - Partners in decision making
 - Most important allies
 - Education & support
- Non-blaming, strengths-focused



Intensive Team

Without EPI

- Disciplines operate independently or with minimal communication
- Large caseloads common

With EPI

- **Frequent and structured collaboration**
 - meet weekly to review all participants
 - share decision making and plan
- **Disciplines/expertise on one team**
 - counselor/case management function
 - vocational/academic
 - licensed medical provider (psychiatrist or prescribing nurse)
 - RN (Oregon, international)
 - substance abuse
 - peer support
 - occupational therapy (Oregon, int'l)
- Caseload target approx. 1:10 for total team fte (managed to preserve access and efficiency)



Vocational/Academic Support

Without EPI

- Often unavailable
- Wait for symptoms
- Lowered expectations



With EPI

- Available immediately to all
- Competitive school & work w/support
- Participation based on choice, no pre-screening



Counseling/Case Management

Without EPI

- Limited expertise
- Often limited to clinic

With EPI

- Specialty training & supervision (CBT, motivational interviewing, etc.)
- Focus on person's goals



Medication Management

Without EPI

- Medicine sometimes viewed as stand-alone intervention
- Prescribe for syndrome (diagnosis)
- Higher doses and polypharmacy are common in some places
- Non-adherence seen as “lack of insight”

With EPI

- Medicine is one important tool
- Prescribe to target specific symptoms
- Start low/go slow
- Minimal number of medicines
- Daily dosing, if possible
- Encourage educated decision making and partnership



Transitional

Without EPI

- Common assumption that person will stay in care indefinitely



With EPI (Oregon):

- Assumption that person will transition into individualized supports
- Planning for long-term supports begins early; supports should be in place before discharge
- Team available for problem solving and check-ins post-discharge



Toward a U.S. National Policy

April 2014 paper from NIMH- **The early findings from RAISE, combined with current body of evidence:**

“are so compelling that the question to ask is not whether early intervention works for FEP, but how specialty care programs can be implemented in community settings throughout the United States.” *

Changed environment:

- Congressional mandate/Federal Block grant
- Parity law
- Expanded insurance coverage (parental & Medicaid)

*Heinssen, Goldstein, & Azrin. (2014). Evidence-Based Treatments for First-Episode Psychosis: Components of Coordinated Specialty Care. Available on-line at url <http://www.nimh.nih.gov/health/topics/schizophrenia/raise/summary-of-fep-treatment-components-d9-11apr-2014-final-edits-for-briefin.pdf>

Why It Matters

- “We are a conspiracy of hope and we are pressing back against the strong tide of oppression which for centuries has been the legacy of those of us who are labeled with mental illness.”
 - Pat Deegan,
<https://www.patdeegan.com/pat-deegan/lectures/conspiracy-of-hope>



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Thanks for joining us in the conspiracy!

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