EASA Center for Excellence

OHSU Portland State University | SCHOOL OF PUBLIC HEALTH

Changing the Experience of People with Early Psychosis in Alaska

Session 1: 11/15/23

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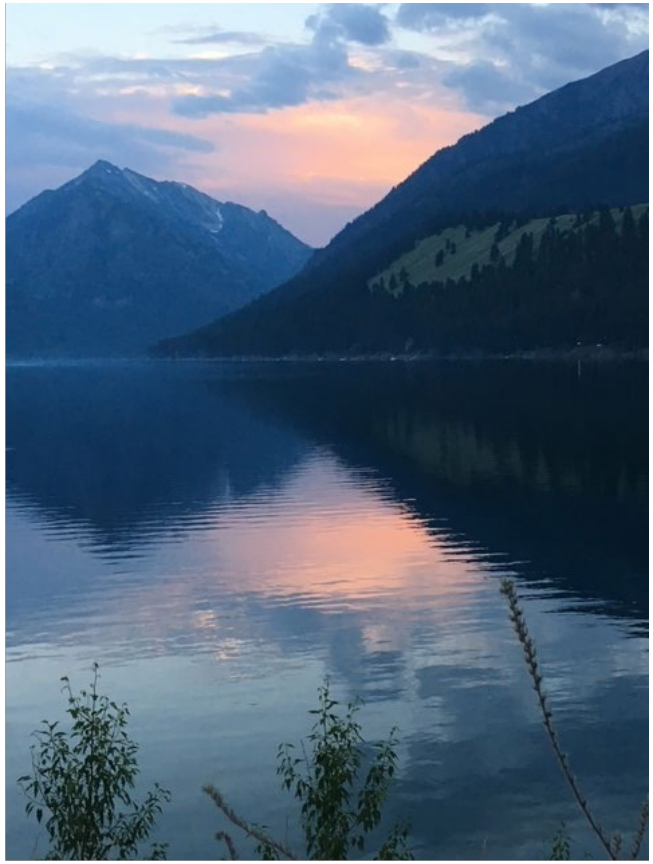
Early Assessment and Support Alliance (EASA)

The EASA Center for Excellence, EASA C4E, is part of the OHSU-PSU School of Public Health in Oregon. With support from the universities and Oregon Health Authority, EASA C4E is a nationally recognized research, training, consultation, and technical assistance organization for early psychosis intervention programs in counties across Oregon, as well as nationally.

Goals today

a) Start building a network of folks working toward common goals in Alaska

b) Review and consider application core elements and practices of early psychosis intervention and why they matter



Webinar 2:

- Resources and approaches for each element and practice
- Bringing it home with different levels of resource

Introductions

1- Name, pronouns, role, location

2-***One of the following:***

- One thing you *learned from a person who experiences psychosis*
- One thing that is *special about* the place or group you consider as *community*
- How you got your name and what it means to you

How we introduce ourselves matters!

Example: Introducing Tamara

-What expectations does this introduction create?

-What feelings is it likely to induce in the person/about the person?

Example 1: This is Tamara. She experiences delusional thinking and sleep disruption. She often doesn't complete work responsibilities on time and can be a helicopter mother with her daughter. She is compliant with treatment but often doesn't follow through.

Example 2: This is Tamara. She places a great value on community and tries hard to do her best work. She is creative and honest and has a trusting relationship with her daughter. She can get overwhelmed sometimes by complex information and sometimes needs reminders. She enjoys walking around her neighborhood and talking to the neighbors.

How we introduce ourselves and each other matters!

Think of someone you know who experiences schizophrenia or another condition involving psychosis.
OR Think of someone you know age 15-28 who has experienced a condition considered to be a mental illness.

Without violating privacy, consider how you might introduce them in a consultation, and write a brief introduction in chat.

“I’m a person with schizophrenia” vs. “I’m an artist who enjoys wildlife”.

Learning over the years…

- Early psychosis intervention in Oregon grew from the experiences of people feeling/observing that what we were doing wasn't working and seeking answers
- The Early Assessment and Support Alliance in Oregon grew from 5 counties in 2001 to statewide beginning 2007
- Technical assistance center started 2013
- Continuing to develop as we work with each new community
- Part of a national & international movement

Psychosis as continuum

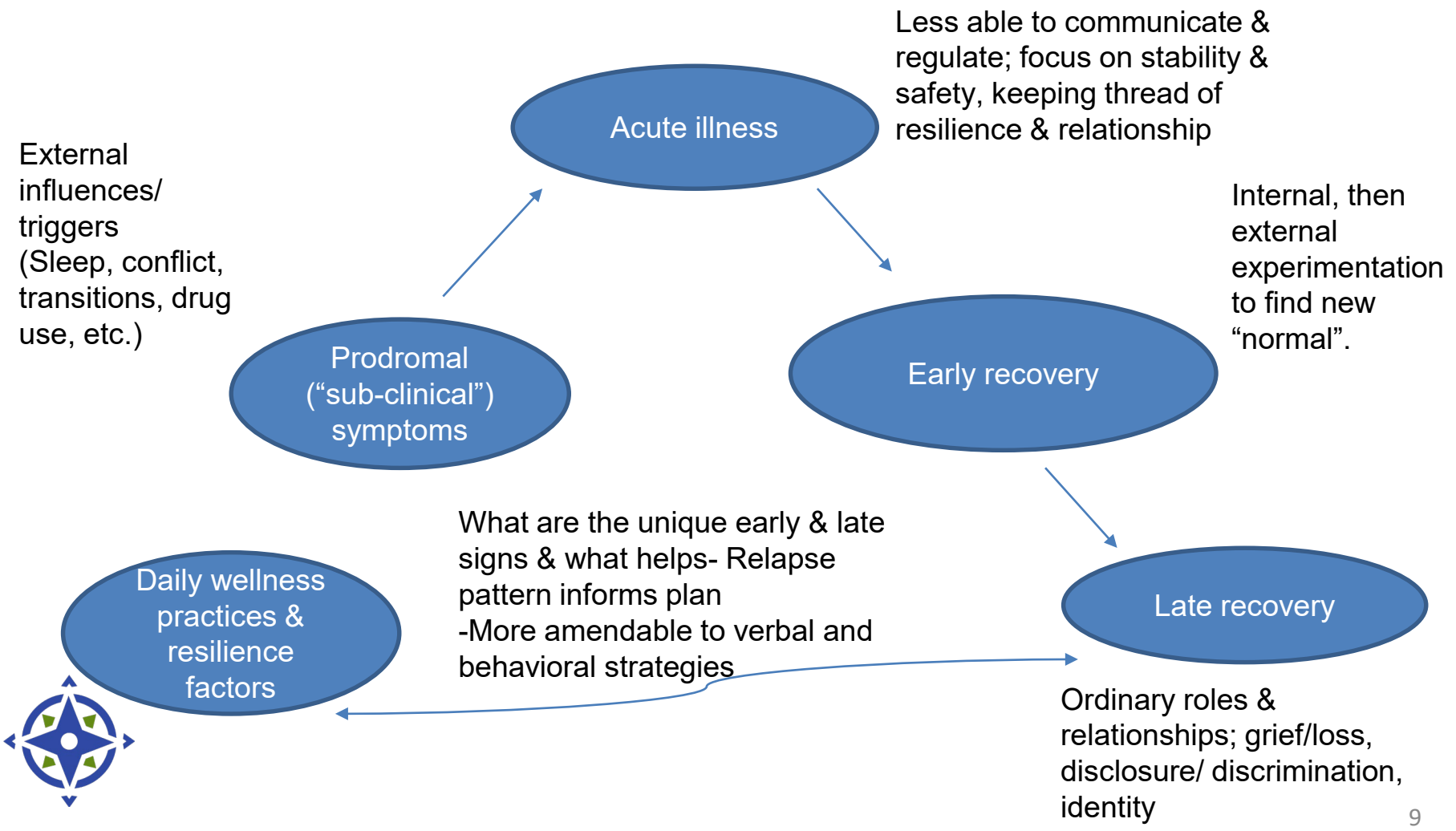
https://www.easacommunity.org/the-young-adult-leadership-council.php

- Onset is often gradual
  - Changes in intensity, frequency, duration
- Distress/ behavior impact
- Explanation & ability to engage in reciprocal explanation/conversation

Examples:

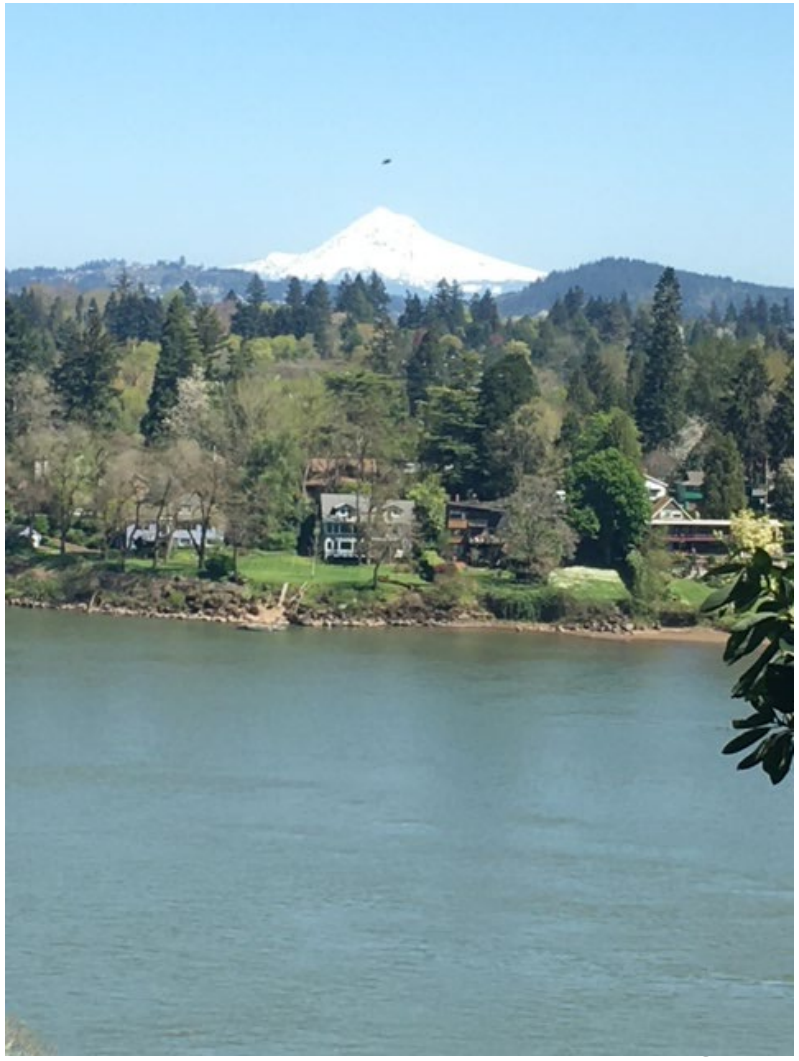
- Sensory distortion/intensity vs. **hallucinations** vs. acting on them
- Neurocognitive signs/"Over-valued ideas" vs. **delusional beliefs** amenable to reality testing vs. delusional beliefs not amenable to reality testing
- Ability to communicate vs. unusual/disorganized language vs. speech that is not understandable ("**thought disorder**")
- Ability to move and coordinate body vs. disorganization/ **movement symptoms**

Psychosis onset/relapse cycle (individual relapse signature)



What is the common experience in your community vs. what you would hope for?

- Finding help
- Access to care
- Underlying beliefs, values, language (expected outcomes)
- Services offered
- Continuity vs. fragmentation (“coordinated specialty care- mitigates)
- Ongoing roles
- Socioeconomic well-being



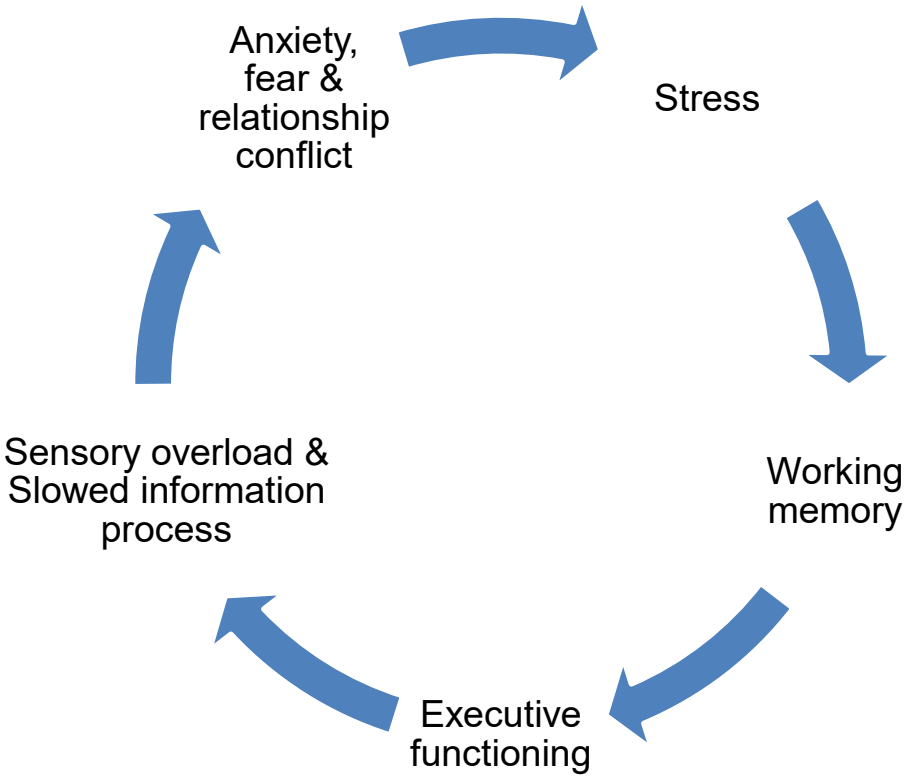
Social vs. Clinical Disability

- Relationship is not as direct as one might expect
- Individuals with severe clinical symptoms can perform well socially and individuals with minor clinical symptoms can have large impacts on functioning

- Social and role engagement (school/work, social interaction, tasks) can help structure thought processes

- Variables:
  - Social support and roles
  - Nature of symptoms (intrusiveness, negativity)
  - Level of distress
  - Level of external criticism and negativiy
  - Internalized stigma

Accommodations for psychosis



Accommodations for psychosis

- Welcoming
  - Genuine interest & curiosity
  - Don't negate the person directly; help them connect the dots
- Working memory
  - Talk about one thing at a time
  - Write things down
  - Use memory tools
- Stress/overwhelm/executive functioning challenges
  - Take a step-by-step approach
  - Write it down
  - Side-by-side vs. direct eye contact
  - Follow their lead; slow down if needed
  - Don't expect them to remember
  - Reduce stress

Accommodations for psychosis

- Effects on reality testing, executive functioning (getting from here to there)
  - Outreach and proactive welcoming engagement without requiring "motivation for treatment"
  - Include support system from beginning
  - Listen and observe for what they care about and the language they use
  - Be specific, concrete, curious
  - Help connect the dots.

- Slowed processing speed
  - Pause for understanding and response
  - Simplify and repeat

Accommodations for psychosis

- Misunderstanding/performance pressure & conflict in environment
  - Offer illness education and problem solving
  - Normalize conflict
  - Provide accommodation strategies (extra time, etc.)
- Anasognosia
  - Focus on what the person is motivated by however simple
- Sleep disruption/reversal
  - Schedule around the person
  - Pay attention to drug side effects
  - Include sleep as a treatment goal; teach sleep strategies
- Discrimination & internalized stigma
  - Be an ally & advocate
  - Check understanding of language & don't push language with negative connotations

Philosophy and approach

- Shared decision making & partnership with individual & family
- Proactive outreach and follow-up
- Reduce barriers
- Strengths exploration as foundation: values, interests, relationships, resources
- Focus on developmental progression
- Coordination across disciplines and supports
  - Weekly coordinating meeting
- Minimize intrusive interventions wherever possible
  - “Start low, go slow”
- Planful approach-
  - Relapse prevention focused on symptom exacerbation, environmental triggers &
  - Transition planning

Core Goals and Approaches

- Early identification
- Engagement of individual
- Engagement of family
- Strengths & values exploration
- Risk assessment & crisis response
- Comprehensive assessment & treatment planning
- Illness education
- Coping and symptom management
- School/work support
- Skill development
- Practical resources for living & developmental progression: school/work, relationships, housing, etc.
- Relapse prevention planning & rehearsal
- Connection to formal & informal long-term supports

Discussion

- Questions
- How you see it applying