<table>
<thead>
<tr>
<th>Common Experience</th>
<th>Intended Result</th>
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| **Community lacks awareness.**  
- There is a general lack of knowledge about psychosis.  
- Many people have negative assumptions about outcomes.  
- Families don’t know where to turn. | **Community is aware and prepared.**  
- Community members receive basic information about psychosis and how to get help.  
- Places where families turn first are prioritized for outreach: doctors, schools, etc. |
| **It is difficult to get help.**  
- Symptoms create barriers (paranoia, delusions, etc.).  
- There are many mental health system barriers (expectations that the person is seeking help; eligibility restrictions, unwillingness to talk to families, restrictions on outreach).  
- Long delays (1 year or more) are common. | **It is easy to get help.**  
- Connection to 24 hour response.  
- Prompt outreach by trained professionals to individuals and families.  
- Regulations, policies and procedures support flexible outreach for psychosis. |
| **Families are ignored by professionals.**  
- Family communication is often an afterthought.  
- Families receive little information or support.  
- Families suffer from trauma, grief and overwhelming responsibility. | **Families are active partners.**  
- Communication occurs within 24 hours of referral, then ongoing.  
- Counselors focus on family as well as individual needs.  
- Families receive extensive education.  
- Support groups, conferences and informal networking events offered. |
| **Risk assessment limited to “imminent threat” of danger.**  
- Involuntary commitment standards often determine whether a person gets help. | **Risk assessment is comprehensive and proactive.**  
- Psychosis is always viewed as high risk.  
- Assessment looks at a range of risk factors (delusional beliefs, impulsiveness, access to vehicles or weapons, family support, etc.).  
- Crisis plans are developed. |
| **There is little attempt to support the person’s normal developmental progress.**  
- Emphasis is on symptoms, medicine, and stabilization. | **Developmental progress is a primary focus of assessment and support**  
- Emphasis is on mastery of symptoms, personal goals and developmental needs. |
| **Negative assumptions about schizophrenia predominate.**  
- Professionals are quick to assume and communicate that the person will be unable to live a normal life. | **Positive, realistic assumptions about schizophrenia predominate.**  
- Emphasis is on successful ongoing management of symptoms and movement toward personal goals.  
- Professionals communicate the expectation that with an active recovery process the person can have a fulfilling life. |
| People are given the chance to meet successful role models. | The treatment process is often coercive. Disagreements are labeled “non-compliance”. People are given directions and expected to follow. Clinical language is used. |
| Personal choice is always sought and respected. Relationships are built on self-identified goals and needs. Professionals build on the person’s interpretations and language. Honest communication about choices is encouraged. Information to help improve choices is provided. |
| Individuals and families often receive little information about their illness and methods of coping. | Individuals and families receive extensive information about the illness, symptom management, and successful recovery. |
| Mental health assessment often under-emphasizes medical testing to rule out possible causes of symptoms. | A list of medical tests is ordered for all people with psychotic symptoms. |
| High doses of medicine are common. Side effects lead to decreased functioning and choice to stop taking medicine | Medicine is prescribed at low doses and gradually tapered up as needed. Careful attention is given to symptoms and side effects. |
| Services focus on keeping people who have long-term needs out of the hospital. Work and school are often discouraged as a “high-stress” activity. A minimal level of functioning is accepted. Group activities mix people with long-term negative outcomes with young people. | Services focus on helping people move on with their lives while learning the skills to stay out of the hospital. A strong focus is placed on vocational and educational support. Individuals are encouraged to learn about relapse planning, workplace accommodations, etc. Groups and activities specifically for young people are provided. |
| People in recovery play little or no role in service design. | People in recovery provide oversight, feedback and direction for service design. |

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