

## Common Experience Versus Intended Result of the Early Psychosis Services

Common Experience	→ Intended Result
<p><b>Community lacks awareness.</b></p> <ul style="list-style-type: none"> <li>√There is a general lack of knowledge about psychosis.</li> <li>√Many people have negative assumptions about outcomes.</li> <li>√Families don't know where to turn.</li> </ul>	<p><b>Community is aware and prepared.</b></p> <ul style="list-style-type: none"> <li>√Community members receive basic information about psychosis and how to get help.</li> <li>√Places where families turn first are prioritized for outreach: doctors, schools, etc.</li> </ul>
<p><b>It is difficult to get help.</b></p> <ul style="list-style-type: none"> <li>√Symptoms create barriers (paranoia, delusions, etc.).</li> <li>√There are many mental health system barriers (expectations that the person is seeking help; eligibility restrictions, unwillingness to talk to families, restrictions on outreach).</li> <li>√Long delays (1 year or more) are common.</li> </ul>	<p><b>It is easy to get help.</b></p> <ul style="list-style-type: none"> <li>√Connection to 24 hour response.</li> <li>√Prompt outreach by trained professionals to individuals and families.</li> <li>√Regulations, policies and procedures support flexible outreach for psychosis.</li> </ul>
<p><b>Families are ignored by professionals.</b></p> <ul style="list-style-type: none"> <li>√Family communication is often an afterthought.</li> <li>√Families receive little information or support.</li> <li>√Families suffer from trauma, grief and overwhelming responsibility.</li> </ul>	<p><b>Families are active partners.</b></p> <ul style="list-style-type: none"> <li>√Communication occurs within 24 hours of referral, then ongoing.</li> <li>√Counselors focus on family as well as individual needs.</li> <li>√Families receive extensive education.</li> <li>√Support groups, conferences and informal networking events offered.</li> </ul>
<p><b>Risk assessment limited to “imminent threat” of danger.</b></p> <ul style="list-style-type: none"> <li>√Involuntary commitment standards often determine whether a person gets help.</li> </ul>	<p><b>Risk assessment is comprehensive and proactive.</b></p> <ul style="list-style-type: none"> <li>√Psychosis is always viewed as high risk .</li> <li>√Assessment looks at a range of risk factors (delusional beliefs, impulsiveness, access to vehicles or weapons, family support, etc.).</li> <li>√Crisis plans are developed.</li> </ul>
<p><b>There is little attempt to support the person’s normal developmental progress.</b></p> <ul style="list-style-type: none"> <li>√Emphasis is on symptoms, medicine, and stabilization.</li> </ul>	<p><b>Developmental progress is a primary focus of assessment and support</b></p> <ul style="list-style-type: none"> <li>√Emphasis is on mastery of symptoms, personal goals and developmental needs.</li> </ul>
<p><b>Negative assumptions about schizophrenia predominate.</b></p> <ul style="list-style-type: none"> <li>√Professionals are quick to assume and communicate that the person will be unable to live a normal life.</li> </ul>	<p><b>Positive, realistic assumptions about schizophrenia predominate.</b></p> <ul style="list-style-type: none"> <li>√Emphasis is on successful ongoing management of symptoms and movement toward personal goals.</li> <li>√Professionals communicate the expectation that with an active recovery process the person can have a fulfilling life.</li> </ul>

	<ul style="list-style-type: none"> <li>√People are given the chance to meet successful role models.</li> </ul>
<p><b>The treatment process is often coercive.</b></p> <ul style="list-style-type: none"> <li>√Disagreements are labeled “non-compliance”.</li> <li>√People are given directions and expected to follow.</li> <li>√Clinical language is used.</li> </ul>	<p><b>Personal choice is always sought and respected.</b></p> <ul style="list-style-type: none"> <li>√Relationships are built on self-identified goals and needs.</li> <li>√Professionals build on the person’s interpretations and language.</li> <li>√Honest communication about choices is encouraged.</li> <li>√Information to help improve choices is provided.</li> </ul>
<p><b>Individuals and families often receive little information</b> about their illness and methods of coping.</p>	<p><b>Individuals and families receive extensive information</b> about the illness, symptom management, and successful recovery.</p>
<p><b>Mental health assessment often under-emphasizes medical testing to rule out possible causes of symptoms.</b></p>	<p><b>A list of medical tests is ordered for all people with psychotic symptoms.</b></p>
<p><b>High doses of medicine are common.</b></p> <ul style="list-style-type: none"> <li>√Side effects lead to decreased functioning and choice to stop taking medicine</li> </ul>	<p><b>Medicine is prescribed at low doses</b> and gradually tapered up as needed.</p> <ul style="list-style-type: none"> <li>√Careful attention is given to symptoms and side effects.</li> </ul>
<p><b>Services focus on keeping people who have long-term needs out of the hospital.</b></p> <ul style="list-style-type: none"> <li>√Work and school are often discouraged as a “high-stress” activity.</li> <li>√A minimal level of functioning is accepted.</li> <li>√Group activities mix people with long-term negative outcomes with young people.</li> </ul>	<p><b>Services focus on helping people move on with their lives</b> while learning the skills to stay out of the hospital.</p> <ul style="list-style-type: none"> <li>√A strong focus is placed on vocational and educational support</li> <li>√Individuals are encouraged to learn about relapse planning, workplace accommodations, etc.</li> <li>√Groups and activities specifically for young people are provided</li> </ul>
<p><b>People in recovery play little or no role in service design.</b></p>	<p><b>People in recovery provide oversight, feedback and direction for service design.</b></p>

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 Tamara Grace Sale [salet@ohsu.edu](mailto:salet@ohsu.edu)