Early Psychosis Intervention in Oregon and the U.S.

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What I Will Cover

• Why Early Psychosis Intervention
• Momentum within the U.S. and internationally
• What it includes
• Challenges and opportunities for partnership
Schizophrenia

- Approximately 1 percent of population but disproportionate costs
- Hallucinations, delusions, thought disorder, movement disorder
- Negative symptoms (blunted affect, avolition)
- Cognitive and sensory changes

The Need for Early Psychosis Intervention

- Common onset in teens and young adult years, often gradual
- Affects all life domains including identity development
- Current system: barriers to access, delays, ineffective care, crisis-driven, high cost
Huge Costs, Terrible Results

- **Cost to society** $62.7 billion dollars in 2002 (Wu, 2007)
- **Treatment delay and lack of access to effective care.** (Drake & Essock, 2009).
- **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).
- **Unemployment** over 80% (Salkever et al. 2007)
- **Victimization, suicide, homelessness**
  - *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).
  - One study found that one in five people with schizophrenia had no fixed address (Folsom 2005).

Goals of Early Psychosis Intervention

- Early identification
- Rapid response and voluntary engagement
- Provide effective education and support
- Reduce symptoms or impact of symptoms
- Maintain developmental progression
- Transition into long-term support
1960s
• Deinstitutionalization
• Community Mental Health Centers created

1980s
• Community Support Systems Movement (case management)
• NAMI created
• Early psychosis research beginning (Australia, UK)

1990s
• Early Psychosis Prevention & Intervention Center, Melbourne
• OPUS and TIPS studies (Denmark & Norway)
• Clozapine
• U.S. and Canadian universities begin investigating onset process leading to North Atlantic Prodrome Longitudinal Study (NAPLS)
• “Decade of the Brain”: U.S. research funding

2000
• Oregon Early Assessment and Support Team (EAST) in 5 Oregon counties: 1st integration in public mental health system
• Portland Identification and Early Referral Service (PIER): First population-based research study in U.S. focused on psychosis risk syndrome
• Broad dissemination in Commonwealth countries

2004
• IRIS in U.K.; International Early Psychosis Declaration
• California millionaire’s tax led to local early psychosis program development

2007
• Robert Wood Johnson Foundation funded six-site EDIPPP study based on PIER
• Oregon legislature began funding statewide dissemination; EAST became the Early Assessment and Support Alliance (EASA)

2010
• National Institute of Mental Health funded RAISE study (first federally funded demonstration of early psychosis intervention)

2014
• Congressional action created 5% Mental Health Block Grant set-aside for early intervention with serious mental illness including psychosis
• By 2015, programs in 29 states
Coordinated Specialty Care

• Community education and outreach

• Shared caseload across intensive team serving under and over 18

• Transdisciplinary: medical, vocational, counseling, peer support

• Integration of evidence-supported approaches

Evidence-Based Approaches

• Shared decision making and feedback informed processes

• Medical practices (low dose, tapering, avoiding polypharmacy, careful attention to side effects, wellness strategies)

• Cognitive behavioral therapy, motivational interviewing

• Family psychoeducation

• Individual Placement and Support (IPS) vocational support

• Evidence supported/consensus: outreach, peer support
Targeted Outcomes

• Reduced treatment delays
• Success in managing symptoms and moving forward with developmental milestones
• Family and social support engagement
• Ongoing voluntary, empowering participation in care

RAISE ETP (Navigate) Results

Impact of Coordinated Specialty Care

- CSC participants remain in treatment longer
- CSC improves outcomes over 24 months
  - overall quality of life
  - measures of symptoms
  - interpersonal relations
  - involvement in work or school
- Participants with shorter duration of untreated psychosis derive substantially more benefit from CSC

Kane et al., in press, American Journal of Psychiatry
EASA

• 94% of Oregon’s population have specialty team available
• Approx. 500 people served per year
• Most families actively involved
• Steady decline in hospitalizations
• Majority not pursuing disability funding
• Increase over time in school/work participation

Challenges

• Referent education and pathways to care
• Financing team-based approach in public mental health
• Mobility across insurers and geographic areas
• Cultural and rural adaptations
• Consistency of long-term supports
Private Insurance vs. Mental Health Center

PRACTITIONER RESTRICTIONS: Fund hospitals & licensed individual practitioners, not licensed mental health centers

ACCESS RESTRICTIONS: Sometimes don’t take private insurance or Medicare; may require disability plus Medicaid

SERVICE RESTRICTIONS: Core elements not covered by insurance (family psychoeducation, outreach, team-based care, case management)

DIFFERENT REGULATORY FRAMEWORK: Licensing at clinic rather than individual level; Medicaid is driver

Context

• Affordable Care Act and Parity:
  • Privately insured people have the least access to appropriate care!

• Legal rights (Olmstead): Large percentage hospitalized and re-hospitalized

• Medicaid expansion: Young adults and mental health centers no longer have to apply for federal Disability System for insurance
Opportunities for Collaboration

• Designing services from young adult focus- are they accessing health care?

• Defining and implementing pathways
  • Early identification & rapid referral
  • Physician and health plan member education
  • Long-term transitions

• Financing coordinated care based on current evidence
  • Alternative payment methods/ case rate or daily rate
  • Accountability for rapid response

• Ongoing service improvement
  • Data sharing- hospitalizations, ER use
  • National level: NIMH EPINET

• National Association of State Mental Health Program Directors portal: http://www.nasmhpd.org/content/early-intervention-psychosis-eip

• Prodrome and Early Psychosis Network (PEPNET): http://med.stanford.edu/peppnet/whoweare.html

• National Psychosis Prevention Council: http://psychosisprevention.org/

• International Early psychosis Association: www.iepa.org.au

• EASA: www.easacommunity.org

• RAISE study resources: http://www.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode-psychosis-resources.shtml

  • Navigate (RAISE Early Tx Program manuals): www.navigateconsultants.org
  • RAISE Connections/ OnTrack USA (implementation and treatment manuals): http://practiceinnovations.org/OnTrackUSA/tabid/253/Default.aspx


• PIER Training Institute: http://www.piertraining.com/

• Felton Institute/ PREP: http://prepwellness.org/training/
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