# EASA_LOGO_horiz_final.eps

# Common Experience versus Intended Result of

# Early Psychosis Intervention

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| ***Common Experience Without EASA*** | ***Intended Result of EASA*** |
| **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 often 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.**  People can call the team directly.  Prompt outreach by trained professionals to individuals and families.  Regulations, policies and procedures support flexible outreach for psychosis. |
| **Families of young adults are often 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. |
| High doses of medicine are common. Side effects lead to decreased functioning and choice to stop taking medicine | **Medicine is normally 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.** |