

EASA Introductory Training Session 2

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Last session: you learned about EASA Philosophy

- Understand EASA goals, structure, history and resources
- Review EASA tasks and how transdisciplinary teams function
- Review core knowledge about psychosis and onset
- Review community education goals and processes
- Begin to review standards and processes related to access and engagement

This session:

You will learn about EASA practice

- Introductions and debriefing from homework
- From referral to transition--our core principles and practices surrounding:
 - Screening and engagement
 - Assessment
 - Treatment
 - Transition
- Homework for next session



Introductions and Reflecting on Community Ed Exercise

- Your name, role, where you work
- Something I learned/thought differently about
- Something I would like to know more about/
get better at



EASA Roles and Tasks





EASA CORE PROCESSES

- ✓ Proactive community education
- ✓ Flexible outreach and engagement
- ✓ Family support and partnership
- ✓ Strengths and person-centered
- ✓ Careful risk assessment
- ✓ Attention to school and work
- ✓ Introduction to others who have had similar experience
- ✓ Psychoeducation
- ✓ Medical & wellness support
- ✓ Finding meaning, making sense of experience, developing mastery
- ✓ Developmental progress
- ✓ Relapse planning
- ✓ Transition

What we are attempting to impact

(adapted from Dan Fisher's "Personal Assistance for Community Existence"):

Health and well-being

Developmental progression and resources, including:

- 1. Empowering beliefs-** Hope, belief in the likelihood of a positive future, future orientation
- 2. Maintaining and building relationships-** people who believe in you and never give up, who make you feel safe & you can trust. People who have had similar experiences. People who care, who let you recover at your own pace.
- 3. Skills-** Forming emotionally meaningful connections, self care, self responsibility, self forgiveness, setting & achieving personal goals, expressing uncomfortable feelings.
- 4. Identity-** Not defined primarily by illness, recalling past successes, overcoming stigma, becoming whole again
- 5. Community-** Valued social roles, helping others



Common experiences of early and later recovery

- May be hard to interact in the beginning, overwhelming physically and emotionally; grief is common
- Withdrawal does not mean inactivity (figuring things out)
- May start experimenting to test out others' reactions
- Sometimes can take 6-9 months before people start feel more comfortable interacting
- Later recovery: Begin to gain confidence; social anxiety often still an issue
- Often want to give back to others, learn from experience



Returning to John...

- Re-read the engagement part of the scenario
- Write in the chat box: What STRENGTHS do you see that might help you engage with John and his parents?



Engagement strategies

- Choose a comfortable location.
- Try side-by-side.
- Acknowledge viewpoint despite what is said.
 - LEAP (Amador): Listen, Empathize, Agree, Partner
- Be flexible, empathic, active and helpful.
- Socialize, focus on interests/strengths, especially those you have in common. Identify common ground or create it.
- Explain procedures & write things down with clear instructions.
- Gather assessment information gradually and in the form of storytelling (aids in memory and identifying negative cognitions and stigma.)
- Learn about family and youth culture.
- Use simple sentences.
- Say one thing at a time.
- Allow plenty of time for response.



The purpose of SCREENING

- Engage with and understand family's point of view and needs; provide initial education and coaching
- Crisis response as needed
- Gaining ENOUGH clinical information (symptoms, onset, to determine fit for EASA)
- If NOT appropriate for EASA, figuring out where the best fit is and helping to access those services
- Building trust and engagement
- Facilitating rapid access
- Beginning to collect info for the comprehensive assessment

(Guidelines 5, 7, possibly 13)



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KHL, 12:47

Acceptance to EASA Scenarios

- Clear psychosis consistent with schizophreniform or bipolar- Bring in immediately!
- Clear psychosis but uncertainty about etiology- use best clinical judgment and make rapid decision about acceptance; do more thorough assessment later (SCID)
- Symptoms which may be schizophrenia prodrome- Do SIPS
 - Can use PQB to determine whether to do SIPS
 - SCID recommended
- SCID recommended at some point (not always at entry)
- Diagnostic ambiguity is normal
- Full range of services when people enter
- If later diagnosis is outside EASA's normal scope:
 - we still provide care until we can transition gradually to appropriate services
 - Can be for full EASA duration or partial depending on clinical need and appropriateness



Orientation to Early Psychosis Services (individual & family)- Guidelines 5, 7, 9

- Address immediate needs and concerns
- What to expect (short-term and long-term): engagement/assessment, phases of treatment
- Who is on team & how to access them
- What team members do and how they work together (coordination, assessment, treatment planning, family engagement, harm reduction)
- Basic psychoeducation
 - Crisis resources (make sure they have 24-hour number)
 - Family guidelines
 - Relevant illness education: impact of gradual onset, symptoms
 - Communication and normal family reactions
 - How relevant system(s) work (HIPAA, FMLA, 504/IEPs/college disability services, legal, crisis, etc.)



Assessment is...



- **Iterative (frequent and repeating).**
 - Gradual
 - Is narrative: drawn from how people share their personal stories
- **Existential**
 - Involves inquiring about risks right way
 - Includes crisis planning and crisis resource sharing up front.
- **Inclusive**
 - Family Input Form
 - Cultural Formulation Interview (in DSM-5)
 - Past evaluations
 - Health form
 - Observation/conversation
 - Team members' experiences with individual and family
- **Complex**
 - Incorporates both the person's lived experience and story *AND* structured or semi-structured diagnostic interview data. It is a Both/And opposed to Either/Or.

(Guideline 6 & 13, 14)



Routine Medical Tests for Psychosis

- CBC with differential
- Comprehensive Chemistry panel (Electrolytes, BUN/CRT, with liver transaminases)
- Urine drug screen
- Urinalysis, with microscopy
- B-12 and folate
- Thyroid screen (TSH, Free T4)
- MRI or CT as indicated
- Sleep deprived EEG as indicated



(Guideline 6)

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1:05

Formulation takes a lot into account...

- History:
 - What changed? When?
 - What is your explanatory model?
 - What's made things worse? Better?
 - What was your pathway to care?
- Risk factors: guns in the home? Past or present suicidality/homicidality, thoughts of hurting self/others.
- Past Experience with Mental Health Treatment: therapies, treatments that worked or did not, whether they felt coercive or collaborative
- Medical Problems: head trauma or other traumas
- Allergies
- Developmental history: birth and attachment history, developmental milestones, scholastic history including learning challenges, school experience (504p/IEP, evals)
- Substance Use
- Sociocultural Factors: Individual and family culture, religion and spirituality, sexual preference and experiences, gender identity, interests and pursuits
- Needs and goals across life domains



Strengths assessment: purpose

- Engagement
- Treatment goals and strategies
- Crisis and relapse prevention methods
- Job, career development
- Reinforcing and building self esteem, sense of identity, hope, confidence
- Reinforcing and building social networks

(Guideline 10)

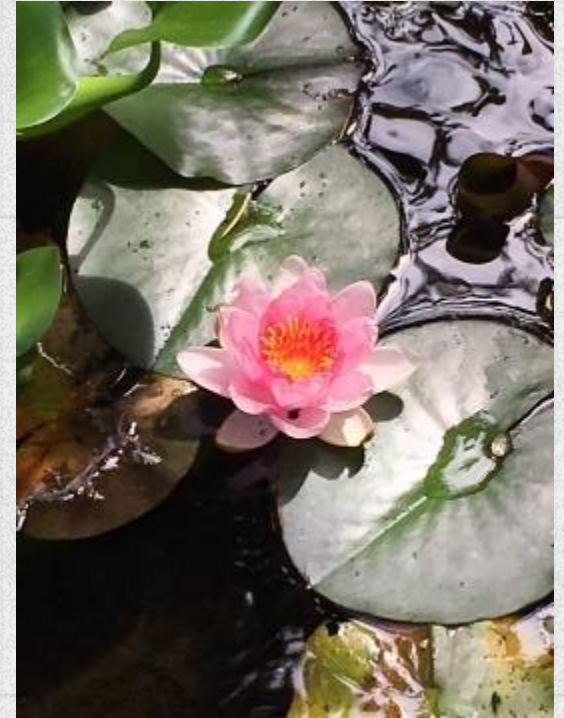


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TK, 1:25

Emphasis across Life Domains

- ✓ Housing/Living Situation
- ✓ Financial/Insurance
- ✓ Vocational/Educational
- ✓ Social Supports/ Relationships
- ✓ Health
- ✓ Leisure/ Recreation
- ✓ Spirituality/ Culture



Source: University of Kansas



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TK, 1:15

Strengths Exploration

- What makes you resilient and helps you keep going?
- What helps you grow?
- What are your skills? In what did you feel successful in the past?
- What do you do for fun? What did you used to do for fun? What do you like?
- What interests you? What do you enjoy learning? (What used to interest you)?
- Who do you like? Who supports you?
- What places do you go?
- What do you dream about?
- What music do you listen to? Websites do you like? What do you like about them?
- What do you like about the place you live?
- What do other people appreciate about you?
- A couple of resources:
 - www.mittrainingtoday.com (teen values card sort)
 - www.cade.uic.edu/moho/resources (interest checklist)
 - NAVIGATE IRT strengths section (internal strengths focus):



John: Sample strengths assessment



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TS, 1:25,
break to
1:40

What are your experiences with using the strengths assessments?

- Chat box time!
- Common challenges with using strengths assessments.
- Solutions!



Comprehensive risk assessment

- Current or past suicidality, exposure to attempts and/or death by suicide
- Health concerns
- Delusional content (for example: perceived threat, focus on bodies of water, loss of boundaries)
- Impulsivity
- Social support loss/ family conflict/ potential victimization
- Current or past violence
- Current or past victimization
- Substance use
- High level of distress/ hopelessness
- Family, Individual, other professionals

(Guideline 10)



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KHL, sample,

1: 50

Substance Use

- Common developmentally
- Addressed within the team
- Harm reduction
- Motivational interviewing
- If refer out for more intensive care it is helpful to educate the other provider and assess whether messages are consistent.

(Guideline 1 & 10)



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TS 1:55

Substance abuse assessment and treatment resources

- NAVIGATE Individual Resiliency & OnTrack New York modules
- Dual Diagnosis Capability Resource:
 - Self-assessment: Click to add text
<http://www.centerforebp.case.edu/client-files/pdf/ddcmhtindex.pdf>
 - Follow-up and training resources:
<http://www.centerforebp.case.edu/client-files/pdf/ddcmhtttoolkit.pdf>

TS, 1:57



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Guideline #6: Treatment planning

- What does this person want to accomplish?
 - How are symptoms getting in the way and how can team help?
 - Goals should be primarily in the person's words and should be owned by the person, measurable with time frames and roles
 - All members of the team contribute
 - All team activities should be on plan and relate back to the person's goals and priorities
 - Frequent revisions
 - Might need adaptations in agency EHR
- Avoid:
 - Controlling the conversation and taking away the person's voice.
 - Pushing the person into things that are outside their comfort zone



Guideline #3: Clinical High Risk

- Do not assume they will develop psychotic illness (majority do not within 24 months); focus on stress-vulnerability and prevention
- Antipsychotics not generally used unless there is rapid escalation with distress/impact on functioning
- Strongest evidence: Family psychoeducation & CBT
- Psychosocial- functional/developmental support



Guideline #8: FACT meeting

- Purpose: To closely coordinate and collaborate weekly care with all team members.
- Strategies for success
- Frequency: at least weekly
- Shared document/spreadsheet
- Includes **all** EASA team members (ok to have telepsychiatrist and remote team members call-in)
- Hold meeting even when a team member is not available
- Focus on tasks for the current week
- Highlight successes, concerns, and action steps, identify barriers, briefly problem-solve

TK 2:10



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Weekly Review Format

Person	Family	Coun/c s mgmt	SE/Sed	Peer Support	Medical	OT	Success/ strengths	Transiti on date
John	Met with mom Jo Anne; she is worried and wanting help. Conflict between parents. Meeting dad for coffee Friday. Strong faith healing orientation.	Finish comprehensive assessment and tx plan	Wants to finish high school and go to college to study agriculture . Katie to introduce SEE Wed at 1.	Had first conversation with John. Meeting Thurs. at 2 to expand strengths assessment, explore goals.	Meeting scheduled Wed at 12. Katie to transport.	Schedule assessment of school needs and family	John is engaged in conversation. Still enjoying playing guitar.	Feb 2019
Tamara	She is not interested-join with family	MI work around THC use	John doing practice interviews.	Going together to self-help group at	Establishing PCP. Team to help with	Complete sensory & cognitive assessment	Did three job interviews. Thinking TK 2:12	7/1/17

Guideline 13: EASA Psychiatry and psychopharmacology

Things providers and participants need to talk about



Comic by Shane Nelson + Craigan Usher



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CU: 2:19

Shared Decision Making

sound clinical
judgment

best
research
evidence

listening for /
eliciting
participants' and
families' values
and preferences

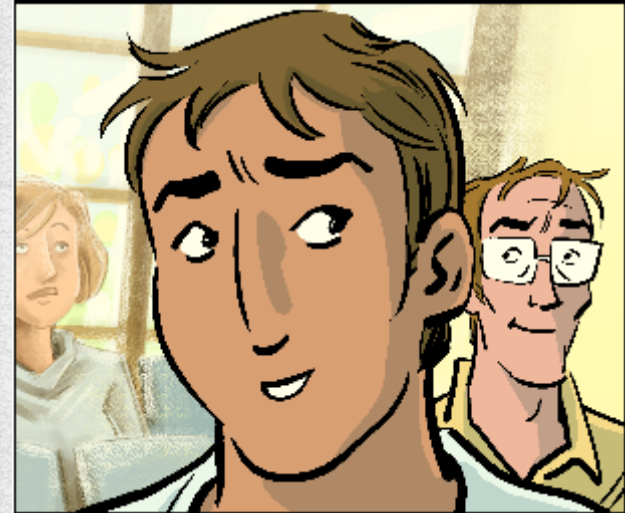


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CU 2:22

Talking About Diagnosis

- Goal: Shared explanatory model which helps the person move forward
- Transparency: Always explain how you are making decisions and involve the person (i.e. introduce DSM-5, etc.)
- Focus on specific symptoms that interfere with goals opposed to addressing overarching label.
- Recognize diversity of condition and experience, different cultural beliefs.
- Be aware of internalized stigma and discrimination
- Examine how diagnoses can be helpful or harmful
- Acknowledge ambiguity, uncertainty



- Be aware: agreeing on diagnosis is a surrogate outcome (one that doesn't really matter); **Functional improvement is the intended outcome.**



Guideline # 13: Psychiatry/Psychiatric Nurse Practitioner Role

- Appointment available within 1 week
- Psychiatrist integrated team member/shared appointments.
- Weekly in the beginning; never less than monthly
- Minimum half hour appointments
- On-going, even if not interested in medications
- Can provide consultation to family members (with appropriate permission)



Medication Treatment

- Coordinated with life goals and team
- Conservative: start low and go slow with consideration of titration
- Avoid polypharmacy
- Careful attention to side effects!
- Careful consideration of tapering after extended remission
- Use relapse prevention plan to inform and guide safe titration and promote shared decision-making



Medication

- EASA Medication Guide:

<http://www.easacommunity.org/PDF/easa-med-guide.pdf>

Table 2: Moving from “just a med visit” to a meaningful meeting!

	Repeat back what you learned for clarity. For example: “It sounds like what is most important to you is not feeling so tired. Is that right?”
Learn what is important to the participant.	Make explicit when what is most important to the individual sounds or appears different than what their family members, friends, or others feel is most important: “From what I’m hearing, it sounds like your parents are concerned about seeing you angry and frustrated. Would you say that’s right? Or: “Do you agree with your parents point of view? Is this something that you think is important to work on?”
Explicitly invite participants in decision-making.	An example: “Today I would like to talk with you about medications. I would like to share with you what I know, learn what you know about medications, and then make a decision together.”
Present options and provide information on benefits and risks.	Participants need to know about the full array of management strategies - writing this down can be helpful. For example, why would they want to take quetiapine instead of lurasidone? What are the

Physical health: Metabolic Syndrome

- Cluster of metabolic risk factors
 - Insulin-resistance, hypertension, cholesterol + triglyceride elevations, increased abdominal girth
- Higher risk for cardiovascular diseases and type 2 diabetes
- Sometimes present at entry into program
- Medications can induce this syndrome
- Early mortality is huge concern



Guideline 14: Nursing and health

<https://www.youtube.com/watch?v=0R4x8Bnko0Y>

- Health care coordination + education
- Primary care and medication assistance
- Side-effect monitoring and education
- Administering shots as needed
- Healthy lifestyle support
 - Sleep
 - Exercise
 - Nutrition
 - Tobacco cessation
 - Safe sex



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Guideline 12:Supported Employment & Education

- Supported employment/education should be highly visible, easy to access from DAY 1
- Preference, not symptoms, is the guide
- Rapid job/school search
- Competitive settings based on person's interests
- Focus on benefits (often more focused on private insurance, vacation, financial aid, etc. than on social security-related)
- Discussion of disclosure decisions (pros and cons)
- Follow-along support
- Ongoing relationship development with employers and schools
- Specialized focus for one person on team

TK 2:55



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Guideline #11: Occupational Therapy

Targeting areas of OT supports the independent living skills that are developing alongside identity development and our understanding of ourselves in relation to the environment.

When a young person experiences psychosis these areas are being newly challenged. If not supported with clear goals or the areas identified specifically, this could compromise development alongside their peers into the next life stage

TK: 2:57



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Role of Occupational Therapy

Purposeful activities to support skill development and holistic wellness through goal oriented participation in the following areas:

Identify routines, roles, and habits , and future needs

Understanding of the sensory system and how to identify individual specific needs for work, home and leisure

Activities of Daily Living and Instrumental Activities of Daily living

- hygiene, sleep, medication management, safety, budgeting, home management, transportation, and community resources

Developing positive coping strategies to support participation

Cognition and identifying areas to support for occupation

- i.e. attention, problem solving, memory, exec. function age appropriate

- Consultation available with the Center for Excellence when an OT is not present on the team to aide in treatment planning with an OT perspective



Peer Support Roles

- Community education
- Engagement and orientation
- Mentoring around developmental issues and illness management
- Helping the person to find voice and self-advocate
- Assessment of strengths and needs
- Community integration and support
- Psychoeducation
- Transition support
- Encourage participation in feedback mechanisms



Guideline # 10: Counseling

- Counseling tasks can be covered by anyone on EASA team.
- Therapeutic interventions with evidence for best outcomes:
 - Goal setting & family psychoeducation
 - Individual psychoeducation
 - Cognitive Behavioral Therapy (CBT)
 - Motivational Interviewing
 - Mindfulness
 - Emotional regulation
 - Reality testing
 - Relapse prevention planning
 - “Wellness toolbox”



Psychosis relapse prevention

- Relapse signature- unique content, timing/sequence, intensity
- Review what changed during prodromal period
- Use checklist of common early signs to cue the person
- Identify day-to-day preventive strategies
- Identify early and later strategies
- Make sure the plan is shared
- Rehearse the plan
- Review and revise as needed
- **EXAMPLE: John**



Stress Bucket



Feedback Informed Treatment

Crucial to successful engagement and outcomes

- Deliberately asks about experience and effectiveness with provider in session.
- Can usually predict drop-out within first three sessions
- Feedback Informed Treatment training January 29, 2018, 9 am pacific!!!



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Homework

1. Complete or update*, share with your team and submit EITHER:
 - A. A strengths assessment along a brief description of how you used it in your role
 - OR
 - B. Relapse prevention plan
2. Send to redacted/deidentified BY SECURE EMAIL to us, along with a description in writing of:
 1. How you are incorporating the strengths or relapse prevention plan into your practice
 2. How you are sharing it with your team members so it informs their work as well

*Can be done with other team members.



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Next Session

(February 7, 8:30-11 pacific/9:30-12 mountain)

- Feedback-informed treatment (Jan 29 webinar)
- Psychoeducation (individual and family)
- Transition
- Clinical supervision
- Ongoing training, TA and program development



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